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ABSTRACT

The information contained in this report is presented in accordance with the goal to develop by 1975 improved procedures and techniques for the identification, diagnosis, and prescription teaching of exceptional prekindergarten children. The first section of the report is concerned with the analysis of the data collected in the Early Childhood Special Education Survey and from case studies of ten Title VI, ESEA, funded Early Childhood Education demonstration projects throughout the state. The second part of the report is a collection of recent research information on early childhood special education. The information obtained from these surveys should help the Office of the Superintendent of Public Instruction identify the status of early childhood special education in Illinois and plan for future needs. The report may also provide necessary information to other states who are just beginning to work in this area. (Author/CS)

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STATE OF ILLINOIS

OFFICE OF THE SUPERINTENDENT OF PUBLIC INSTRUCTION

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INTRODUCTION

The information contained in this report is presented in accordance with Illinois House Bills 322 and 323 (1971) and Action Goals for the Seventies: An Agenda for Illinois Education, a document in which the Superintendent of Public Instruction and the people of Illinois have jointly outlired some of the expectations for Illinois education in the coming years.

This particular report refers to Action Objective #3 which states:

> By 1975, develop improved procedures and techniques for the identification, diagnosis and prescription teaching of exceptional prekindergarten children.

The first section of the report is concerned with the analysis of the data collected on the Early Childhood Special Education Survey and case studies of ten Title VI, ESEA, funded Early Childhood Education demonstration projects throughout the state. Both the survey and the case studies are referred to in the progress report of the second edition of Action Goals for the Seventies. Section two is a collection of recent research information on early childhood special education.

SECTION I

COMPONENTS OF EARLY CHILDHOOD INTERVENTION IN ILLINOIS

CHAPTER I

STATUS OF EARLY INTERVENTION IN ILLINOIS

History

Special education for preschool handicapped children in Illinois began in 1943 when legislation was passed, permitting enrollment of three-year-old "physically handicapped" children into special education programs. Physically handicapped was defined as visually handicapped, orthopedically and health handicapped, and children with impaired hearing. In 1965, the law was amended so that educational programs were required after July 1, 1969, for physically handicapped children.

In 1971, House Bill 322 was passed. It recognized children with learning disabilities as a separate classification eligible for special services, and it also stated that children with learning disabilities be accepted into school programs at age three.

House Bill 323 amended the school code to include socially maladjusted, emotionally disturbed, educable mentally handicapped, trainable mentally handicapped and speech defective children as eligible for preschool special education services. This bill was also passed in 1971, and was to be enacted (made mandatory) July 1, 1972. The intent of House Bill 323 is to provide special education services to an identifiable group of handicapped children not served in public schools who are between three and five years of age. Since accurate diagnostic instruments for such young children are not available, explicit category determination is discouraged.

Inasmuch as public schools have never traditionally served preschool children, the Office of the Superintendent of Public Instruction (OSPI) made 1972-73 a year of planning, program development, and preparatory activities so that the local districts could develop exemplary preschool programs.

During July, 1973, OSPI sent Early Childhood Special Education survey forms to both the local districts and special education cooperatives in the State of Illinois, as early childhood program administrative arrangements vary between the two. In Illinois, a special education cooperative can be developed by joint agreement between school districts in order to provide maximal special education services to their communities. The joint agreement is considered a service agent of the participating districts, and is a cooperative program directed by and responsible to all participating local districts. Of the state's total of 80 joint agreements, 68 are represented in some manner in this chapter. In some cases, the cooperative returned the survey for the districts it serves; in other cases, individual districts that constitute a cooperative submitted the form. (However, the data on the following pages does not include information from the Chicago district since they did not return the survey.)

The information obtained from the surveys should assist OSPI in identifying the status of early childhood special education in Illinois in order to plan for future needs. It may also provide necessary information to other states who are just beginning to work in this area. A copy of the survey form is found in Appendix A.

Development of the Survey

The following information is a result of the computation and analysis of the returned survey form. It should be kept in mind that the figures in

this section represent grcss information; sites were not requested to maintain exact data throughout the year.

Every school district was sent a survey form. It was the responsibility of the Local Education Agency (LEA) to decide whether or not to complete the form or delegate it to the special education cooperatives.

Identification

Each LEA and/or special education cooperative used their own identification methods and procedures. Below are the results of the question on the survey form which focused on identification methods.

Table 1.1 Identification Methods and Procedures

	During 1972-73 School Year		Projected for 1973-74 School Year	
	Yes	No	Yes	No
Publicized screening and program services using local media	119	9	118	8
Contacted public and private agencies serving handicapped children	100	20	108	21
Contacted all local preschool programs	88	35	108	20
Contacted local pediatricians	70	49	92	35
Publicized screening and program services widely in the community by using posters, flyers, and brochures	73	46	85	32
Conducted door-to-door campaign to inform parents about screening and diagnostic services	14	102	15	96
Held a prekindergarten registration for all children	67	50	70	35

Looking at the projected information for the 1973-74 school year, there appears to be a significant increase in local effort to contact pediatricians and local preschool programs.

Screening

The identification techniques enabled 23,876 pre-kindergarten children to be enrolled in screening during the 1972-73 school year. Of that 23,876 pre-kindergarten children, 4,077 were identified as needing additional services after the screening process. This figure comprises approximately 18% of the total number of children screened. There is a 16% decrease in the projected number of pre-kindergarten children who will be screened during the 1973-74 school year.

Table 1.2 Number of Children Screened and Identified as Potentially Handicapped

School Year	1972-73	1973-74
Screened	23,876	20,086
Potentially Handicapped	4,077	Unknown

A census breakdown of the total number of three-and-four year-olds in the state is unavailable, so further statistical analysis concerning a percent of the total state pre-kindergarten population is impossible.

Various screening instruments were used by LEA's and/or special education cooperatives. Table 1.3 is a list in rank order of the instruments used.

Table 1.3 Screening Instruments

Instrument	Frequency
DIAL	45
Own Instrument	20
Vision & Hearing Screening	17
Peabody Picture Vocabulary Test	15
*Vineland Maturity Index	14
Denver Developmental Screening Test	12
Speech & Language Survey	12
*Stanford Binet	12
Wechsler Preschool/Primary	8
Social-Medical Information	8
Developmental Checklist	7
Personal Interviews	6
*Merrill Palmer	5
McCarthy Scale of Children's Activity	4
Cattell Infants Intelligence Test	4
Illinois Test of Psycholinguistic Ability	4
Goodenough-Harris Draw-A-Man	4
APDC Test	3
Bayley Scales of Infant Development	3
Beery-Buktenica	3
Gross Motor/Fine Motor	3
Leiter International Performance Scale	2
Hiskey-Nebraska	2
Observation Techniques	2
Slosson	2
Detroit	1
Automated Graphogestalt	1
*Preschool Attainment Record	1
Utah Test of Language	1
Gesell	1
Wepman	1
Ammons	1
Winterhamm	1
Purdue Perceptual Motor Survey	1
Goldman-Fristoe	1
Otis Lennon	1
Early Detection Inventory	1
Preschool Developmental Screening Test	1
Waukegan Early Entry	1
Meeting Street Screening Test	1
Developmental Task Performance Test	1
Mecham Verbal Language	1
Frostig	1
Minnesota Preschool	1
Bryngelson Articulation	1
Northwestern Syntax	1

*Scales listed in the Guidelines for House Bill 322/323 Appendix B.

Developmental Indicators for the Assessment of Learning (DIAL), a screening device designed by OSPI, was the most frequently used instrument. A point to consider here may be one of economics, since districts using DIAL were reimbursed $1.00 per child.*

Besides the various instruments used, a great many of the responses indicated that the parents completed a questionnaire or developmental checklist. For the 1972-73 school year, 100 responded as having used a parent questionnaire. Very few, if any, of the LEA's attached an example of their parental checklist. The projected information for the school year 1973-74 indicates only a very slight increase (101) in the number of parents expected to complete a questionnaire.

During 1972-73, approximately 1,392 staff members and 1,014 volunteers participated in the screening procedures and methods. The breakdown according to profession is noted in the following chart.

Table 1.4 Staff Involved in Screening

Number of Psychologists	208
Number of Speech and Language Clinicians	342
Number of Early Childhood Specialists (Academic training in early childhood education or child development)	87
Number of Nurses	240
Number of Volunteers	1014
Number of Paraprofessionals	176
Number of Social Workers	97
Number of Special Education Teachers	242
Other (specify)	91
Total	2497

*For further information see: Dr. Steve Lapan, Final Report: External Evaluation of Project DIAL. Mimeographed paper, August, 1973.

The category listed as "other" was comprised of administrators, guidance counselors, Title VI staff, remedial reading teachers, occupational therapists, Title III staff, psychologist interns, DIAL trained administrators, physical therapists and social workers.

Diagnosis

There ware a variety of individuals involved in the diagnostic procedures. The following is a list in rank order, of the staff involved.

Table 1.5 Rank Order of Diagnostic Staff

Staff	No. of Responses
Speech & Language Clinicians	99
Psychologists	97
Nurses	87
Special Education Teachers	81
Pediatricians	53
Social Workers	52
Early Childhood Teachers	50

The large number of pediatricians used in the diagnostic procedures could indicate referral systems rather than direct involvement in the diagnostic procedures.

The category "other," was comprised of regular classroom teachers, audiologists, psychiatrists, neurologists and otologists.

Each LEA and/or special education cooperative selected their own diagnostic procedures. The chart below illustrates the procedures used.

Table 1.6 Diagnostic Procedures

	1972-73		Projected 1973-74	
	YES	NO	YES	NO
Classroom Observation	62	36	73	18
Home Interview and Observation	81	19	85	11
Medical Evaluation	86	13	85	6
Formalized Psychological Evaluation (List Instruments Used)	81	14	85	9

Very few of the LEA's attached a list of the psychological evaluation instruments that were used.

Medical evaluations, formalized psychological evaluations, home interviews and observations were the most frequently used diagnostic procedures for the 1972-73 school year. However, there is a slight decrease in the projected number of medical evaluations for the 1973-74 school year. Information regarding the number of children diagnosed as needing additional services after the screening is not available.

Services

A total of 1,524 pre-kindergarten children were served during the 1972-73 school year. The following table lists the number of children served according to disability.

Table 1.7 Number of Children Served According to Disability

	During 1972-73 School Year	Projected for 1973-74 School Year
Number of Physically Limited	722	646
Number of Mentally Impaired	453	686
Number of Developmentally Delayed	349	1490
TOTAL	1524	2822

Table 1.7 shows the breakdown by disability of the children to be served. The LEA's and/or special education cooperatives have envisioned that 20,086 pre-kindergarten children will be involved in screening during the 1973-74 school year. Of this figure, the districts estimate they will serve approximately 2,822 children. The LEA's estimate that the number of developmentally delayed will increase 4.4 times that of the figure of the 1972-73 school year.

As service to physically limited children has been mandatory since 1969, it is not surprising to note that almost twice as many physically limited children were served (1972-73) as compared to the number of developmentally delayed. However, for the 1973-74 school year there is a slight decrease in the projected number of physically limited. The projected overall total of children served for the 1973-74 school year has almost doubled.

Based on the diagnostic procedures listed in Table 1.6, the types of services provided to pre-kindergarten handicapped children and the number of students involved in each of the services are discussed in Table 1.8. In considering the data it should be kept in mind that the figures may be duplicated since a child could be receiving multiple services.

Table 1.8 Types of Direct Services

	NUMBER OF PHYSICALLY LIMITED		NUMBER OF MENTALLY IMPAIRED		NUMBER OF DEVEL. DELAYED		NUMBER OF CLASSES	
	During 1972-73	Projected For 1973-74	During 1972-73	Projected For 1973-74	During 1972-73	Projected For 1973-74	During 1972-73	Projected For 1973-74
Classroom Services	350	468	243	435	389	854	147	282
Itinerant Services (Supplemental support services such as speech therapy, that would be provided to a child in a preschool program either funded through the district or by outside funds. i.e. Headstart)	354	394	168	250	567	924		
Home Intervention (Services in the home to the child, parent or both)	155	181	103	182	386	564		
Individual Therapy not in Combination with Classes	58	67	8	62	42	82		
Other (Specify)								

The number of developmentally delayed children receiving classroom services will more than double during the 1973-74 school year. However, itinerant services will remain the main type of direct service. Overall there appears to be a continual growth in the number of children served and the types of services offered.

One of the most interesting results of the survey proved to be the variety and number of staff used.

Table 1.9 provides a breakdown by speciality of the staff involved in providing special education pre-kindergarten program services. The most significant increases in staff for 1973-74 year will include the addition of early childhood teachers and paraprofessionals.

Table 1.9 Staff Members Providing Special Education Prekindergarten Program Services

Number of Teachers in Special Education Areas	1972-73	1973-74
Learning Disabled	238	293
Educable Mentally Handicapped	117	110
Trainable Mentally Handicapped	50	127
Social Emotional Disorders	126	172
Deaf/Hard of Hearing	90	67
Blind/Visually Handicapped	29	42
Physically Handicapped	54	51
Early Childhood Teachers	84	164
TOTAL	788	1026

Number of Others		
Speech and Language Clinicians	244	360
Psychologists	235	260
Social Workers	95	124
Paraprofessionals	116	289
TOTAL	690	1033

In the projected figures for the 1973-74 school year there appears to be a high number of speech and language clinicians and learning disability teachers who will be involved in providing services. Table 1.7 indicates a possible doubling of children, while Table 1.9 indicates that professional staff will only increase by one-third.

Visitation Information

Each district planning services for three-and four-year-old handicapped children was provided an opportunity to apply for a mini-grant of $10,000. The intent of the grant was to supplement local effort and expand already existing programs serving three-and four-year-old handicapped children.

A review committee within OSPI, using an internally developed set of criteria, selected ten sites which were each funded $10,000.00. Sites were geographically distributed to facilitate visitation by people interested in early childhood education for the handicapped. The last page of the survey was devoted to evaluating the visitation information.

Below is a list of the sites and the frequency of visits to each one as indicated by the statewide survey and by mailings of the last page of the survey to people registered in visitors' rosters at the ten sites.

Table 1.10 Frequency of Visits to Sites

Sites	Frequency of Visits
Belleville	14
Aurora	10
Carmi	8
Lawrenceville	10
Ottawa	8
Cicero	5
Jacksonville	4
Proviso	4
Belvidere	2
Pekin	2

Originally, the sites were also to be used as Pilot Observation Projects, but according to the survey data they were not useful in this capacity. Many of the survey forms were returned with comments referring to the fact that they didn't even know that the sites existed. This indicates a problem with dissemination by OSPI and/or the ten sites.

The ten sites were visited by a variety of individuals. Below is an occupational list of those people who visited the sites.

Table 1.11 Visitors by Occupation

Occupation	Number
Director of Special Education	13
Superintendent	9
Psychologist	7
Assistant Superintendent	3
Principal	4
Teacher	4
Nurse	2
Supervisor	1
ECE Coordinator	0

Of the people responding to the questionnaire, 39 felt their visit to the preschool program was useful in giving ideas for the development of local programs, while 8 had negative comments. Of the 39 positive responses, 25 plan to implement some of the ideas presented at the pre-school programs.

The narrative section of the questionnaire revealed valuable information. Below are comments which were taken directly from the question:

In your opinion, how could the Office of the Superintendent of Public Instruction best provide guidance in development of Early Childhood Special Education Programs on a statewide basis?

Inservice training workshops for professionals and para-professionals.

Provide on-site help (from trained ECE specialists).

Encourage student training institutions to offer programs for preparation of teachers in the area of ECE.

Compile listings of developmental guidelines for preschool children stated in behavioral goals.

Provide research.

Don't send forms, send money!

Provide district with lists of visitation sites.

Provide models for screening and evaluation.

Publish summary evaluation reports of ten ECE projects.

OSPI staff should be more positive and service minded.

OSPI should assume the responsibility for the testing and screening of all preschool children. Local districts limited in staff and finance to implement an program.

Continual communication and directions.

Funding.

The chapter which follows describes the ten sites in detail.

CHAPTER 2

DESCRIPTION OF TEN EARLY INTERVENTION SITES

Site Selection

Within the last decade, there has been increasing interest in the education of young handicapped children. Work done with disadvantaged children appears to have been the catalyst for the push for preschool handicapped programs. Since there are so few exemplary programs for these children, Congress, in September of 1968, enacted the Handicapped Children's Early Education Assistance Act to encourage local communities to develop such programs.

Early childhood educators hope that early intervention may prevent or reduce the severity of the handicapping condition(s) and allow for a more "normal" development. It is also hoped that the feelings of inadequacy, unworthiness, or even persecution that may develop as a result of the reaction of the people around such a child, would be diminished through supportive therapy and re-education of those people he comes in contact with. Early education may also diminish a handicap by teaching the child to use a prosthetic device effectively, or to learn appropriate compensatory behavior. Another positive effect hoped for is reduced labeling of children. Many educators feel that labeling a child leads to a self-fulfilling prophesy effect. When a child is categorized as retarded, he is frequently given a watered down curriculum which has the effect of teaching him less than his peers. Often, a label sticks with a child, even when the condition

is no longer evident. Dr. Bakalis, the State Superintendent of Public Instruction, has committed his office to a program which will avoid labels and integrate the handicapped into the regular school setting whenever possible.

The passage of Illinois House Bills 322 and 323, especially 323, caused the Illinois Office of the Superintendent of Public Instruction to look closely at the early childhood education picture in Illinois.

As a result, OSPI decided to allocate $100,000 of Title VI money for one year ($10,000 per site) to ten early childhood sites in Illinois. These communities had gone above and beyond the mandate of the law by implementing preschool programs in the 1972-73 school year rather than using that year only as a planning time period. After perusing the proposals, OSPI awarded the Title VI money to the following sites, all of which incidentally, submitted non-categorical proposals.

1. Aurora Public Schools -- West Side District #129 (Aurora)
2. Belleville Area Special Education District (Belleville)
3. Boone County Special Education Cooperative (Belvidere)
4. Four Rivers Special Education District (Jacksonville, Pittsfield)
5. LaSalle County Educational Alliance for Special Education (Ottawa)
6. Proviso Township Area, Department of Education for Exceptional Children (Proviso)
7. South Eastern Special Education District (Lawrenceville)
8. Tazewell-Mason Counties, Special Education Association (Pekin)
9. Wabash & Ohio Special Education District (Carmi)
10. West Suburban Special Education District (Cicero)

All the sites except Aurora, are in special education cooperatives. In Illinois, such organizational units can be developed by a joint agreement between school districts in order to provide maximal special education services to their communities. The joint agreement is considered a service agent of the participating districts, and is a cooperative program directed by, and responsible to, all participating local districts.

The next section describes the programs at each of the ten sites, in detail, and the reaction of 28 of the participating parents to the programs. Data for this section came from teacher interviews, aide interviews, administrator questionnaires, psychologist questionnaires, classroom observations, and parent interviews.

At the end of the year, as part of Title VI regulations, each site had to submit a final report to OSPI. In this report, as well as on the administrator questionnaire, each site was to specify program strengths and weaknesses as they perceived them. These comments, when given, are included in the following ten site descriptions.

SKETCHES OF THE TEN SITES

Site and Location (#1)

Aurora Public Schools
West Side District #129
80 South River Street
P. O. Box 1428
Aurora, Illinois 60507

Classrooms.....2

Classes.....4
(two morning,
two afternoon)

Teachers.....2

Aides.....1

Criteria for Eligibility

Three- and four-year-old children who displayed significant delays in their development to the extent that any early education program in the community could not be expected to sufficiently meet their needs in preparation for future kindergarten enrollment.

Screening Personnel

Social worker, psychologist, nurse, and teacher.

Screening Methods

1. Vineland Social Maturity Scale
2. Peabody Picture Vocabulary Test
3. Social-medical history
4. Drawings of Geometric Design
5. Goodenough Harris Drawing Test
6. Items from the Clark Motor Scale
7. Parent interviews
8. Child observation
9. Information from referring agencies

Diagnostic Personnel

Social worker, psychologist, two nurses, two teachers, two speech/language therapists, one pediatrician.

Diagnostic Methods

1. Stanford-Binet Intelligence Scale
2. Developmental Diagnosis (Norms such as Gesell & Amatruda)
3. Pediatric examinations
4. Columbia Mental Maturity Test
5. Speech Evaluation Reports
6. Plan interviews
7. Child observation
8. Case conferences
9. Consultation with teachers, speech therapists
10. Reports from parents
11. Peabody Picture Vocabulary Test
12. Purdue Perceptual-Motor Survey
13. Clark Motor Scale
14. Frostig Developmental Test of Visual Perception
15. Vineland Social Maturity Scale
16. Preschool Attainment Record

Referral Agencies

1. Easter Seals
2. Child-Care Agencies
3. Family Physicians
4. School and Public Health Nurses

Supportive Agencies

None Specified

Aurora is located approximately 50 miles southwest of Chicago. There are two school districts within the community -- one in Aurora East, and one in Aurora West.

The community of Aurora West was made aware of the program through personal letters to physicians describing the purpose of the program and through meetings with preschool agency personnel such as Easter Seals. These people alerted parents to their child's possible need for special education services. The parents then contacted the Aurora West school district.

Classes took place in a former orphanage. The entire second floor of the building was devoted solely to preschool children. The teachers had the use of four rooms (two of which were set up for gross motor activities

and art) which they used cooperatively. In addition, a kitchen and specially equipped rooms for the pre-kindergarten classes on the first floor were available at specified times. Two morning and two afternoon groups met five days per week for two-and-a-half hours per day.

On staff, there was one full-time psychologist, two full-time teachers, one full-time aide, one language therapist for three-and-a-half hours per week, and one pediatrician for half-a-day every other week.

The basic comprehensive objectives of the Aurora program were:

1. To foster the emotional and social development of the child by encouraging self-confidence, spontaneity, curiosity, and self-discipline.

2. To promote the child's mental processes and skills with particular attention to the visual perceptual motor areas and language skills.

3. To establish patterns and expectations of success for the child in order to create a climate of confidence for his future learning efforts.

4. To increase the child's capacity to relate positively to family members and others while at the same time, strengthening the family's ability to relate positively to the child.

To achieve these goals, the Aurora teachers set up what they viewed to be an open classroom environment, alternately allowing the children to select their activities or participate in specific tasks designed by the teacher. Whenever possible, cognitive teaching procedures were to be incorporated into play oriented instructional procedures, rather than the traditional tutoring relationship. There was a definite concern that the affective dimension of the child be developed with as much emphasis as the cognitive domain. It was important to the teachers that individual needs be met and that the child would participate actively in the learning process -- learning by doing, utilizing play, field trips, and other activities that would lend themselves to concrete experiences.

There were two preschool teachers who taught morning groups and afternoon groups; they shared the aide. The first teacher's morning schedule was the following: free play, snack time, group activities, table activities, and outdoor play. Her afternoon schedule was: free play, climbing room, art, snack, outdoor play. Within this general schedule, the specific tasks were spontaneous, dependent upon the interests and moods of the children. The second teacher watched her children the first week and built her program around their behavior. There was no planned schedule. Each teacher had individual objectives written down for the children.

During a classroom observation, three children and the aide played with a puppet and blocks, while the teacher played store with two other children. In the other classroom, three children were listening to a story. The teacher was very enthusiastic and animated as she asked the children questions about the story. When she finished reading the story, the teacher brought her children into the first classroom since the teachers had agreed to combine their classes. A third group of more severely handicapped children (not part of the Title VI grant) also joined them. The first classroom now had 11 children, 3 teachers, and 2 aides. Children moved freely about the room selecting or not selecting different activities. The teachers and aides did most of the talking. Except for occasional outbursts by one child, the children played silently. Most of the children played by themselves or with the staff; there was very little child-child interaction. The order and structure that was evident at most of the other sites was not apparent here, nor was it expected. The first teacher commented, "You can't expect them to function in a structured environment."

The aide was involved in teaching, planning and diagnosis. He had a college degree and functioned as another professional in the classroom. He received very little supervision. He would talk about the day's schedule with the teacher before class began, and then he was on his own to work with the children as he saw a need. Feedback on performance worked two ways. At the end of the day, the teacher and the aide discussed how they each handled situations during the day and gave each other ideas on what could be done in the future. The aide felt that there should not be aides in the program, only co-teachers, since whoever was with a child at a particular time took the repsonsibility for handling the child's behavior.

The teachers had inservice meetings with the head teacher once a week and with the psychologist once a week. They also discussed the children informally on a daily basis. Topics for the inservice sessions included: determining the needs and growth of the individual children, setting up goals, discussing plans and procedures, and handling of behavior problems. The psychologist and head teacher provided feedback of their classroom observations noting how they perceived the lessons and suggesting other teaching methods that might be tried.

Neither teacher was involved in the staffing that determined placement. Both kept anecdotal records in order to note current behavior and to look back for changes in behavior and growth. They used three locally developed behavior checklists: Developmental Guidelines, Social Behavior, and Skills Related to Social Adjustment.

Evaluation of the child was based on pretests and posttests, weekly evaluations of his progress, anecdotal records, and parent feedback.

Some of the children were to remain in the program, some would be attending nursery schools, while others were to begin kindergarten in the fall. Local districts were preparing for these students through staffings with the preschool staff and referral to special education when necessary.

It was felt that the parents should become an integral part of the program through their acceptance, understanding and implementation of the instructional process being taught in the preschool. Scheduled individual and group conferences with the parents were planned for the purpose of sharing insights and explaining the program.

Both teachers visited the parents' homes before the children entered the program, and there was a parent meeting during which the parents toured the school. The first teacher called the parents at least once every two weeks to talk about the child's progress. She also sent a newsletter home each week. The second teacher called the parents once every ten days. She sent individual progress reports home to the parents once a week. The psychologist and head teacher provided additional input during parent-teacher conferences.

The Aurora program has not made any plans to change their program based on this year's experience. Their experience "confirmed their belief that providing a constructive learning environment for the young handicapped child is a worthwhile endeavor. Parent response regarding their children's progress has been very encouraging."

Aurora's administrator did express the following concern in his final report: "The determination of those instruments most valid in identifying the preschool handicapped child, and in pointing the direction for the most productive instructional experience is in need of further clarification.

We suspect the clarification of instructional approach most helpful to the preschool handicapped child will continue to be a prime focus of attention in all preschool programs such as this project."

Site and Location (#2)

Belleville Area Special Education District
101 East B Street
Belleville, Illinois 62220

Classrooms..... 2
(a morning and
afternoon group
at each)

Teachers..... 2

Aides..... 2

Criteria for Eligibility

Poor intellectual functioning, poor language development, physical disability, and/or primitive deprivation.

Screening and Diagnostic Personnel

A social worker, a psychologist, a nurse, a teacher, and a speech therapist.

Screening Methods

1. Denver Developmental Screening Test
2. Mecham
3. Vineland Social Maturity Scale
4. Peabody Picture Vocabulary Test
5. Winterhaven Romberg
6. Preschool Attainment Record
7. DIAL (A state developed screening instrument)
8. Parent conferences
9. Home observations
10. Agency conferences
11. Observation of child at regular preschool

Diagnostic Methods

1. Merrill-Palmer Scale of Mental Tests
2. Wechsler Preschool and Primary Scale of Intelligence
3. Illinois Test of Psycholinguistic Abilities
4. Peabody Picture Vocabulary Test
5. Cattell Infant Intelligence Scale
6. McCarthy Scale of Children's Abilities
7. Classroom observation
8. One-to-one teaching
9. Beery-Buktenica Developmental Test of Visual-Motor Integration

Referring Agencies

None Specified

Cooperating Agencies

None Specified

The Belleville Area Special Education District is a cooperative program composed of 28 area elementary and high school districts. It is located in St. Clair County, Illinois. In the center of the district is the city of Belleville, which is located 20 miles from St. Louis.

Community awareness of the preschool program was brought about through information dissemination by district superintendents, Title VI personnel, parent groups, mental health associations and district personnel.

When a child was referred to the special education district, he was screened. If he seemed to show developmental lags, further tests and observations were made. After a complete diagnosis, the special education administrator scheduled a staffing with various disciplines represented as well as parents in order to coordinate case findings and establish individualized developmental goals.

The children attended class five times a week for two-and-a-half hours per day. There were two classrooms, each located at different schools, and each having a morning and an afternoon group. One classroom was located at Wolf Branch School. Although the room was long and narrow, the special education district decided that the cooperative environment of the school would compensate for the size of the room. The faculty of the school had good rapport, and the older children wanted to help in the preschool room. The preschool children were grouped according to need areas, with the more severely handicapped children served in the afternoon.

The typical morning schedule began with a half-hour of free play. A child would select a toy, and the teacher would use that toy to work with the child on fine motor and language concept skills. There were physical activities followed by group language activities. Next came snack, a ten-minute rest period, and then the children went home. The afternoon group had only individual activities that emphasized motor activities.

The children were first observed during a language lesson. The children labeled objects on a felt board as a "dragon" puppet pointed to the objects. Then they told the dragon which object to point to. After the language lesson, the children had a snack with each child given responsibilities for passing out the snack and milk. Behavior modification techniques were used throughout, with the teacher and aide praising appropriate behavior and setting up contingencies.

The aide had assigned tasks and worked with the children on an individual basis. The aide also helped in diagnosis by noting the children's progress, and she sat in with the parents when they visited the school. The aide got feedback on her work through the teacher who would suggest alternative methods for handling situations.

The classroom in Signal Hill was much larger, and served children who were less handicapped and more mature. The teacher's daily schedule included language development (Peabody, DISTAR), social development, motor coordination, visual discrimination and art activities. The teacher taught language, and the aide showed film strips and read stories. Since the aide had a background in art, she directed and implemented the art projects. She got feedback on her work by discussing what she did with the teacher. There were no inservice sessions per se, but the teacher and aide planned their program together.

The children were observed during snack time and during a langauge lesson. They worked on labeling parts of the body using a girl cut-out and a flannel board. The children were called on to name the parts of the body and make complete sentences using the names of the body parts. After the doll was put together, the teacher removed a part while the children had their eyes closed. The children had to tell what part was missing.

A regional inservice is held every fall. Speech therapists, preschool teachers, people from other regions attend these meetings. In the past, out of district speakers have conducted the inservice, but this fall they will use local people.

Both teachers were involved in the staffing that determined placement. The teacher at Wolf Branch kept anecdotal records to note unusual events, improvements, illnesses. The other teacher used anecdotal records to chart the child's progress.

Evaluation was ongoing, with conferences held jointly by teachers, teacher aides and psychologists, parent conferences, and informal diagnostic techniques. At the end of the year, the children were re-evaluated and placed, according to recommendations by the teacher and school psychologist, as well as gains noted on the child's progress record. The children were placed in special classes, regular classes, or continued in the preschool program. Local districts were preparing for these children through staffings with the special education personnel.

Parental involvement activities were minimal due to a need to stabilize the preschool program first. Parent-teacher conferences were held along with phone calls and notes. Some of the parents visited the class and asked for materials they could use at home. The teacher at Signal Hill made home visits

before the class began in January. The other teacher planned to make home visits next year. The school psychologist made some home visits and attended parent conferences. He discussed the program, the progress of the child, on-going planning and future plans.

The most unique feature of the Belleville Preschool Program was the Curriculum Guide and Progress Checklist they developed. The major goal of the program was, through systematic approaches in learning activities, to enable the young handicapped child to achieve more, earlier. In order to do this they felt a special curriculum for early training of handicapped children was necessary. This curriculum was to provide for a systematic developmental approach to learning tasks and have sufficient flexibility so that individual problems posed by handicapping conditions would be taken into consideration when specific goals of a prescriptive nature were to be established.

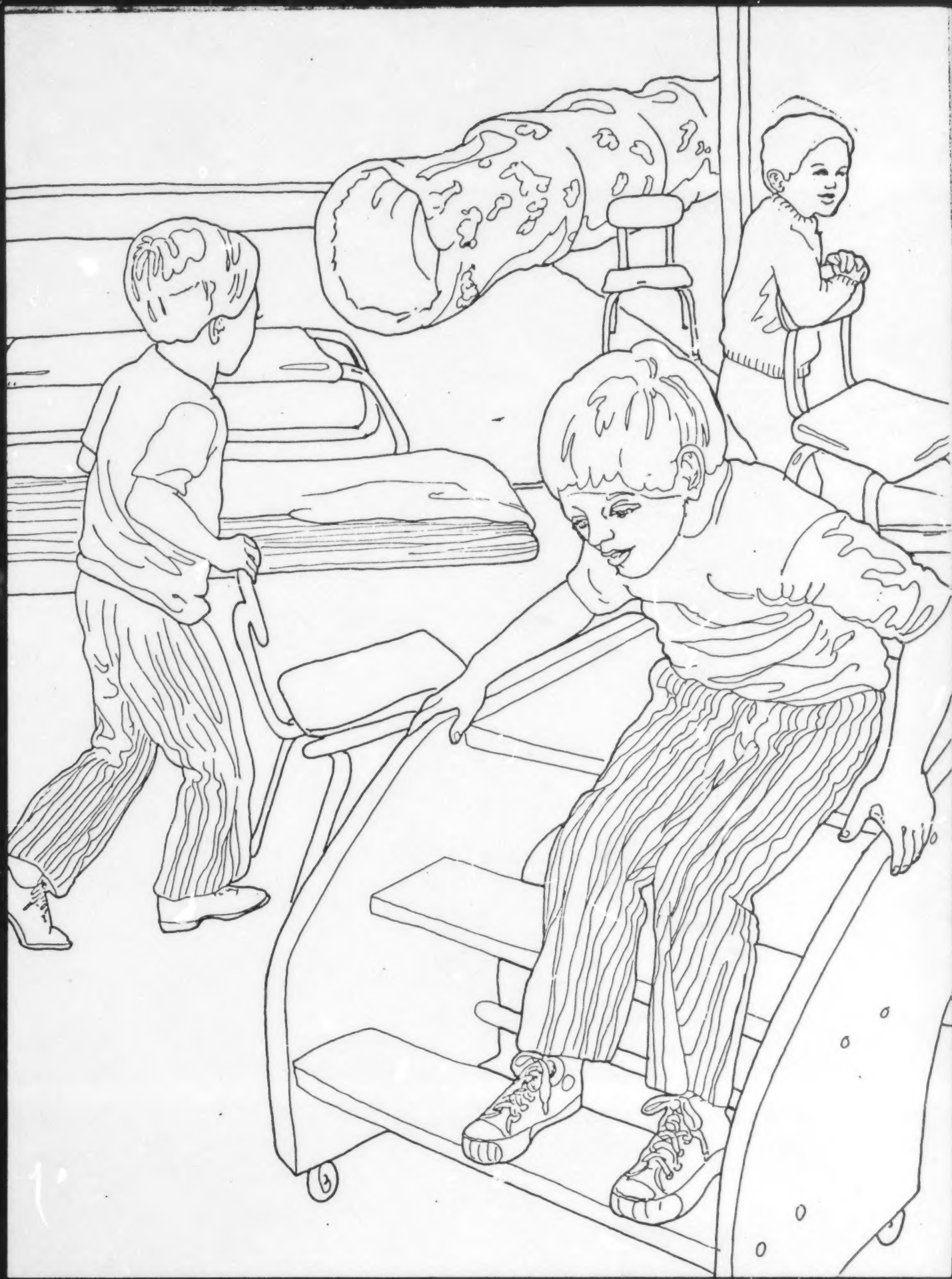
Thes curriculum known as the Belleville Preschool Curriculum Guide and Checklist attempts to aid teachers of the preschool handicapped child determine present levels of attainment, establish realistic goals, and develop appropriate instructional procedures.

Behavioral objectives are established and suggested evaluative tasks are recorded in order that the teacher may use them as a checklist to determine developmental levels and effectiveness of instruction. Much teacher ingenuity is encouraged in developing the activities and materials for the initiation and follow-through of the skills to be evaluated in the final checklist.

Since the success of learning new tasks is dependent on prior learnings, and many tasks, when broken down, require multiple skills to achieve them, there is some overlapping of categories and concepts. Within each category, there

has been an attempt to record the tasks along a continuum to allow for a more accurate measurement of each child at his own stage of development is recorded.

Both preschool teachers worked from this guide and organized their lesson plans around it.



Site and Location (#3)

Boone County Special Education Cooperative
Fifth and Allen Streets
Belvidere, Illinois 61008

Classrooms..... 1
(morning and
afternoon group)

Teachers..... 1
(plus one stu-
dent teacher)

Aides..... 1

Criteria for Eligibility

Exhibition of some form of a physical, sensorial, mental, social, emotional, language or other handicap that required school intervention prior to kindergarten.

Screening and Diagnostic Personnel

Two social workers, 3 psychologists, 8 nurses, 6 student teachers, 16 volunteers, 10 teachers, 4 speech/language therapists, 14 supervisors and administrators.

Screening Methods

1. Parent Home Interviews
2. Locally Developed Child Observation Guides
3. Locally Developed Parent Interview Forms

Diagnostic Personnel

Two social workers, four psychologists, three nurses, three student teachers, two teachers, four speech/language therapists, one pediatrician, and two supervisors and administrators.

Diagnostic Tests

1. Wechsler Preschool and Primary Scale of Intelligence
2. Vineland Social Maturity Scale
3. Beery-Bukentica Developmental Test of Visual-Motor Integration
4. Metropolitan Readiness Test
5. Boehm Test of Concept Mastery
6. HTP
7. Illinois Test of Psycholinguistic Abilities

Referral Sources

1. El Primo Paso (a day care center)
2. The Child Development Center
3. Boone County Day Care Center
4. Boone-Winne County Mental Health Center

Cooperating Agencies

None Specified

The Boone County Special Education Cooperative encompasses districts #100 and #200 in Belvidere and Poplar Grove, Illinois, and is located in the northern part of the state.

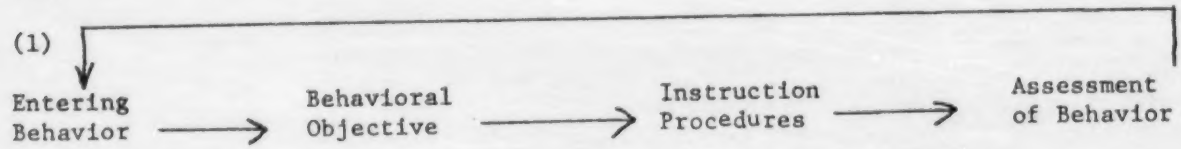
The community was made aware of the program through various media, but principally through group presentations, newspaper notices, word of mouth, and radio-taped spot messages. The community was kept continually aware, through continuation of the above mentioned activities, periodic newspaper articles, and preschool registration activities.

If a child was referred, a home visit was made by school personnel, or the parent was invited to the school for a short interview. If a child went through registration, the parents were interviewed while the child performed simple tasks for a trained observer. Locally developed registration forms, parent interview forms and child observation guides were used.

Diagnostic activities consisted of prescreening children by using DIAL, observing the child two to three weeks during trial placement in the classroom using a teacher-made checklist, and formally testing the children when indicated. If the information was still not complete after formal testing by the psychologist, the child was taken to what was known as the project BOLD diagnostic clinic. This was a clinic set up by the preschool coordinator. It served Boone, Ogilvie, Lee, and DeKalb counties. The

coordinator worked one-fourth time for each of the counties that formed the acronym BOLD. At the clinic, the child was examined by a pediatrician, psychologist, language therapist, and others as needed.

The basic teaching model of the early childhood education program was:



Considerable emphasis was to be placed on the first part of the model (1) to assure, as much as possible, meaningful and realistic behavioral objectives, (2) for each child. Entering behavior (1) was to be defined as the profile of the child gained from the various observations and testings. Behavioral objectives (2) were to be formulated by the early childhood education teacher with the help of the rest of the staff. Appropriate instructional procedures (3) were to be defined in terms of the behavioral objectives and were to be implemented relative to the child's strengths and weaknesses as defined by his entering behavior. The assessment behavior (4) was to be part of the ongoing child study and was to measure whether or not the behavioral objectives were being obtained. When a behavioral objective was obtained, that objective would be used as the entering behavior for the next behavioral objectives.

Approximately eight children came in the morning, and eight in the afternoon, five days a week, for two-and-a-half hours a day. Some of the children had shorter days due to physical problems.

Along with the teacher, the aide, and the student teacher, the following personnel worked intermittently with the children: two psychologists, three speech/language therapists, a physical therapist, a diagnostician for

learning disabilities and educable mentally handicapped, a teacher of the visually handicapped, a teacher of the hearing impaired, and volunteers.

The teacher described her typical daily schedule as the following: snack, directed play (language oriented), story, structured language, perceptual skills, arithmetic, social studies, and music. The language tasks, perceptual skills tasks, and the arithmetic tasks were done in small structured groups. As was described earlier, skills were broken down into their components and then each component was taught to criterion. The teacher described the learning steps as "skill initiated, skill emerging, skill developed, and skill highly developed."

The classroom was large, with cots, blackboards, small tables and chairs, tricycles, a house corner, easels, bulletin boards, and colorful cutouts on the walls. The student teacher was handling the class of seven children for the morning. She was working with three children on colors, saying full sentences and drawing shapes with specific colored crayons. The aide was working with the other four children on verbal expression. She read a story about a picnic and had the children discuss the kinds of food one usually eats on a picnic. The entire class then watched a film-strip about a train. The culminating activity for the day was a "dress rehearsal" of "Goldilocks and the Bears." The children were going to be video-taped performing the story, and the tape was going to be shown to the parents and other interested groups.

The aide had assigned tasks and was involved in teaching and diagnosis. She taught three lessons a day per class (morning and afternoon). She received daily feedback from the teacher during inservice sessions attended by the

teacher, aide, and the volunteers. The aide asked the teacher for advice if she wanted to try something new or if she wanted to make sure she had handled a situation appropriately. The teacher also used a trainee evaluation sheet from the Karnes program at the University of Illinois to provide feedback to the aide.

Two types of inservice sessions were held. One involved the teacher, her aide, her student teacher, and the volunteers. They discussed the children's progress, how to deal with behavioral problems, how to set up materials, and how to become more effective teachers.

The other inservice session involved the diagnostic team. It was held weekly, planned and conducted by the coordinator, and included the following personnel: the classroom teacher, the student teacher, the psychologist, the social worker, the nurse, the itinerent learning disabilities teacher, and the speech therapist. Occasionally the hearing and vision teachers attended. The team continually re-evaluated the children, staffed in new children and discussed screening methods.

The children's final re-evaluation took place in the spring. These evaluations were based on teacher/staff evaluations, pretests and posttests in speech, classroom observation data, skills accomplished, and anecdotal records, which the teacher kept to note emotional problems, toileting problems, and any target problem areas.

Nine children remained in the early childhood program, four went into regular kindergarten with speech and language therapy only, one went to a trainable mentally handicapped classroom, one to an educable mentally handicapped classroom, one to a preschool deaf program. These children were discussed with the receiving teachers by the special education staff.

Parents were invited to visit and assist in classroom activities, but only four parents came to observe.

The coordinator sponsored two workshops for all the parents. She also made home visits and counseled parents when indicated.

The administrator in Belvidere felt that the Title VI grant helped the special education cooperative gain acceptance in the community. Most people in the community viewed special education as service to the educable and trainable retarded. Although the grant money did not go towards public relations, the grant approval gave the cooperative favorable publicity. Because the cooperative is working with preschool children, the image of special education has changed in the community.

Next year, the administrator would like to see a more intensive home-school relationship, with more tutorial services in the home. He would like to get more parents actively involved in the school based program, and he would like to see the weekly narratives to parents become more formalized with (hopefully) more parent response to the reports.

Site and Location (#4)

Four Rivers Special Education District
1724 B South Main Street
Jacksonville, Illinois 62650

Classrooms..... 3
(one morning,
one afternoon)

Teachers..... 3

Aides..... 3

Criteria for Eligibility

Any handicapped child aged three to five that the program could serve.

Screening Personnel

Three psychologists, one nurse, one teacher, one speech/language therapist, and two trained screening technicians.

Screening Methods

1. Pre-screening parent questionnaire
2. Locally developed screening instrument
3. DIAL (a state developed screening instrument)
4. Health and medical records
5. Home follow-up
6. Teaching probes in areas of possible deficits
7. Preschool vision and hearing screening programs

Diagnostic Personnel

Four psychologists, 4 teachers, 16 speech/language therapists, a clinical instructor and an education diagnostician.

Diagnostic Methods

1. Stanford-Binet Intelligence Test
2. Illinois Test of Psycholinguistic Abilities
3. Detroit Tests of Learning Aptitude
4. Beery-Buktenica Developmental Test of Visual-Motor Integration
5. Frostig Developmental Test of Visual Perception
6. Merrill Palmer Scale of Mental Tests
7. Basic Concept Inventory
8. Preschool Attainment Record
9. Southern California Tests of Figure Ground Perception
10. Southern California Test of Tactile Kinesthesia

11. Wepman Auditory Discrimination Test
12. Peabody Picture Vocabulary Test
13. Perceptual Motor Survey

Referral Agencies

1. Nurses
2. Physicians
3. Division of Services for Crippled Children
4. Department of Children and Family Services
5. Department of Public Health

Cooperating Agencies

1. Department of Children and Family Services
2. Division of Public Health
3. Division of Services for Crippled Children
4. Shriner's
5. Crippled Children Association
6. Women's Clubs
7. County Health Department

The Four Rivers Special Education District includes the counties of Brown, Calhoun, Greene, Morgan, Pike and Scott and single districts in Cass, Sangamon, and Macoupin Counties with a total land area of 4200 square miles. The LaMoine, Sangamon, Illinois and Mississippi Rivers form natural boundaries for several of the counties. The entire area may be described as primarily rural in character.

There was mass screening of children at community centers throughout the district for all children under the age of five, but over three. The public was made aware of the purpose of the program through announcements in the press, radio, T.V., and through church and organization bulletins. Screening was coordinated, whenever possible, with the Illinois Department of Public Health or County Health Department preschool vision and hearing screening programs. A pre-screening questionnaire was distributed to, and collected from parents of the target children by community volunteer groups. Children who were

described by their parents as having known handicaps were not screened, but referred directly to diagnostics.

The Four Rivers cooperative had three preschool centers. Two were located in Jacksonville, one in Pittsfield. Each center had a morning group and an afternoon group. Six children received individual instruction at home until the itinerant teacher took a maternity leave in the spring. These children were in the itinerant program because they were either not ready for small group work or because the teacher was able to teach the parents how to work with their child. The parents observed the teacher and gradually began teaching under the teacher's supervision. Itinerant children were seen 45 minutes to one hour, three to five times a week.

Personnel working directly with the children included: a full-time teacher, aide, diagnostician, and clinical instructor; psychologists and audiologists as needed; and a physical therapist three days per week for two hours a day.

As part of the program, there was a Title VI Educational and Clinical Services Center. The purpose of the Center was to:

1. Provide a resource for children whose problems with either undifferentiated or of such a severe nature that long term study and teaching probes were deemed necessary.
2. Provide formative diagnosis which was tested by clinical teaching in the home, day care center or nursery school by the Title VI speech and language clinician.
3. Provide a basis for recommendations for medical evaluation and/or treatment.
4. Provide descriptive formative diagnosis to aid the director and coordinator of early childhood education in selecting options for physical setting, program organization, and delivery of service.
5. Provide educational prescription for early childhood education teachers of diagnostic or categorical classes.

The diagnostic resources of local and state agencies such as the Division of Services for Crippled Children and the Illinois School for the Deaf were used as well as those of private medical specialists.

Implicit in the program was the assumption that the purpose of in-depth child study was to provide information that would help the staff decide the first steps to be taken in diagnostic and clinical teaching, the teaching plan that would most likely serve the child, and the most appropriate setting to provide the services. The major objectives were to remedy, reduce, adapt to, or compensate for discrepencies in the conditions, or growth patterns of children, whether these were innate or acquired, obvious or obscure, generalized or discrete, and whether they were physical, mental, psycholinguistic, social or emotional. Once the children were enrolled in the program, the teacher's daily schedule was the following:

8:00	9:00	Planning and role playing of lessons
9:00	9:25	Directed Play
9:25	9:40	Structure I Language
9:40	10:00	Music and Movement
10:00	10:15	Structure II - Arithmetic
10:15	10:35	Snack & Story (relating this to language)
10:35	10:50	Structure III - Social Studies, Science
10:50	11:00	Freeplay & preparation to go home
11:00	11:30	Evaluation and record keeping

The staff made use of behavioral objectives and criterion tasks, instructional models for content and methodology selection, and pre-planned materials and sequences to relate instruction to specific deficit areas of each child. Daily planning sessions were held by the teachers and assistants; daily progress and problems were recorded. Weekly meetings were held between the teacher, the coordinator and the director, as was inservice demonstration teaching by coordinator, speech and language clinician, physical therapist, principal and

director. Ten additional hours of instruction for teachers' assistants were also planned.

Since all handicapped preschool children were served, many of the children had more severe handicaps such as spinal bifida and cerebral palsy. One class in Jacksonville had children with more severe handicaps because they had started in the program first.

In the first classroom the children seemed to know what was expected of them, and they responded accordingly. At snack time, all the children sat quietly at their table and asked politely for extra portions. Each had assigned tasks for passing out the snacks or throwing away the empty cups and napkins. After snacks, the children moved to a corner of the room for a group activity which included singing, counting and waiting for turns. Praise was used throughout the activities and children were encouraged for attempting to perform tasks.

Observation of the second classroom also occurred at snack time. Since the children were more severely handicapped, snack time was much more of a learning experience. One cerebral palsy child was learning how to feed himself. Another cerebral palsy child pushed herself up from the chair and stood against the table. When she began in the program two months earlier, she had no mobility; she could only lie on her blanket. She could now walk with the aid of a walker.

In the Jacksonville classrooms, both of the aides had college degrees. This resulted in a team approach rather than one professional with one subordinate. The aides assisted in teaching, planning, diagnosis and working with parents.

Both teachers in Jacksonville followed the same general mode of teaching. They each had specific behavioral objectives written down for each child and they used lesson plans to meet the individual needs of the children.

Inservice meetings were held on demand when there was a specific problem to be dealt with. The coordinator and the psychologist would observe the teaching in order to provide feedback later. Feedback was generally provided after class, by demonstration in the classroom or by directions from the aide. There was a greater need for supervision earlier in the program.

One teacher kept weekly anecdotal records based on daily notes. She used these records to plan the next week's lessons and to evaluate the child's skills. The other teacher kept daily anecdotal records to note specific weaknesses or strengths. She also used her records to plan the next week's lessons and kept a checklist to evaluate the child's progress. Neither teacher was involved in the original staffing that determined placement.

The classroom in Pittsfield was a small rented one story house. It had a carpeted floor, T.V., phonograph, shelves, dishes, chairs, refrigerator and stove. During the visitation, the children were working on color discrimination. Each child was given a turn to hand out the correctly colored block requested by the others in the groups. Numeral identification and rote counting were also practiced.

The teacher in Pittsfield had a daily schedule with written individual objectives, and she practiced behavior modification techniques. Initially, her lesson plans had been very specific, but later in the year she felt that she knew the children well enough not to write such

detailed plans. Since the classroom was not located at the center in Jacksonville, this teacher did not get the kind of observer feedback the Four Rivers teacher received. Her aide was not a degreed person. The aide did what she was assigned to do in terms of teaching and she helped in planning. She found the children harder to work with than she expected, but found the work enjoyable.

Parents were to be involved in the early childhood program by:

1. Responding to the Development Questionnaire in the identification stage of the program.
2. Observing in-depth diagnosis while a member of the staff interpreted what was going on.
3. Attending a conference prior to enrollment where they were to be told about program options and their prerogatives.
4. Being trained to do supplemental work with their child.
5. Attending individual conferences, group meetings and using informative materials such as hand-outs, articles.

The parent program did not progress as far as the Four River Special Education District planned. There was no formalized parent education program. Parents were involved only if a need arose. The diverse backgrounds of the parents and the distances between parents made a regular parent program difficult to set up. The Jacksonville teachers generally wrote notes to the parents or talked to them when they picked up their children. A few parent conferences were set up to meet the specific needs of a child. The Pittsfield teacher was beginning to make home visits during April.

The early childhood coordinator set up parent conferences following screening and diagnosis and placement of children in the program. She provided consultive services to teachers on parent conferences and also

provided direct consultation to parents. Evaluation of the program was based on the progress of the children. The program combined formative and summative, formal and informal, subjective and objective methods of evaluation. The goal of evaluation was to improve the curriculum.

Evalaation of the child was based on:

1. the teacher's subjective evaluation of the level of the child's functioning and his progress in the program,
2. objective evaluation done by the Title VI Diagnostic and Clinical Service Center and/or a psychologist, and,
3. staff conferences and recommendations for further educational planning.

Some of the children were placed in kindergarten programs, some in special education programs and some remained in the handicapped preschool program. Planning conferences with local school districts who received children for kindergarten were held after evaluation.

Program successes include the following:

1. Despite demographic barriers and problems, the identification procedures produced good referrals for the early childhood program.
2. Successful methods of disseminating information concerning screening programs that secured the participation of 726 children.
3. Expansion of services through approval by the governing bodies representing all 24 districts.
4. Parental acceptance of early childhood services.
5. Parental and community support for the program.
6. Progress and growth in the children.

Program problems and weaknesses include:

1. Locating appropriate facilities and ordering equipment, supplies and materials at different times during the school year.

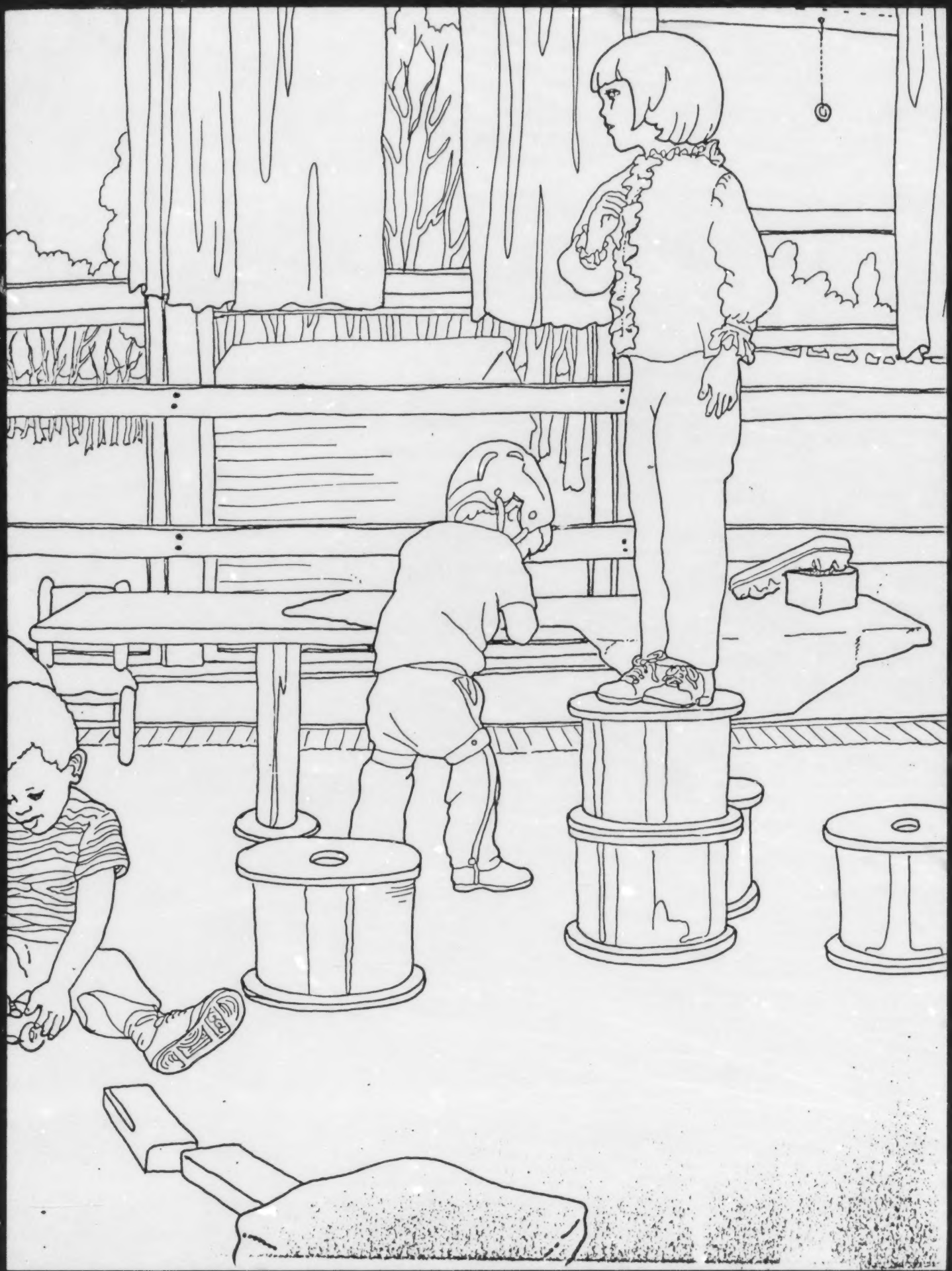
2. A gross underestimation in the amount of time needed to really coordinate the total program.

3. An accumulation of multiply handicapped children occurring in one session, even though an attempt was made to have all programs non-categorical.

4. Inability to develop a system for charting progress of parents and inability to work in depth with some parents to the extent that was desired.

5. Inability to have group inservice training.

6. Feelings by the staff that the children could have benefited more if the staff had known more about what to do and how to do it.



Site and Location (#5)

LaSalle County Educational Alliance
for Special Education
511 East Main Street
Streator, Illinois

Classrooms..... 1
(a diagnostic
room)

Teachers..... 2

Aides..... 0

Criteria for Eligibility

Any preschool child (3-5) who had any presumed handicap or a question as to whether that handicap existed.

Screening and Diagnostic Staff

Seven psychologists, two nurses, three teachers, seven speech/language therapists, one optometrist, one pediatrician, and a social worker.

Screening Methods

1. Preschool Attainment Record
2. DIAL (a state developed screening test)
3. Developmental history of the child
4. Observation of child during
   a. free play
   b. structured activities
5. Use of "How A Child Learns" Analysis Chart

Diagnostic Methods

1. McCarthy Scale of Children's Abilities
2. Stanford-Binet Intelligence Test (Forms L-M)
3. DAP
4. Bender Motor Gestalt Test
5. Selected Subtests of the Illinois Test of Psycholinguistic Abilities
6. "How A Child Learns" Development Chart
7. Observation of parent-child interaction
8. Completion of a developmental schedule based on observation of specific behaviors

Referral Sources

1. Private Nursery Schools
2. Doctors
3. Ministers

4. Parent-Teacher Associations
5. Easter Seals
6. Department of Mental Health
7. Department of Public Aid
8. Local Superintendents
9. Preschool Vision and Hearing Screening Technician
10. Lighted Way

Cooperating Agencies

1. Easter Seal Center
2. YMCA
3. Opportunity School (Developmental Nursery School)

The LaSalle County Educational Alliance for Special Education (LEASE) is a joint agreement of 39 school districts in LaSalle and Putnam counties and covers an area of approximately 1200 square miles.

The program developers had three goals:

1. To develop an effective and efficient means for identifying potentially non-categorical disabled children while they are still preschool age.

2. To establish and validate norms on preschool physical and behavioral traits that would be indicative of probable later school-age handicaps.

3. To develop early corrective programs and procedures for individualized use with the preschool potentially handicapped.

Community awareness was carried out through newspaper articles, radio announcements, clergymen, physicians, nursery schools, a preschool vision and hearing screening program and through the country's allied agencies. Once a referral was made, the local psychologist evaluated the child and formed an opinion as to the adaptiveness of the mother and child to the program. If he felt the family would benefit from the preschool services, he would describe the program to the parents and receive their permission to recommend the child to the project.

The child's records were sent to the diagnostic center, and the child was observed at the center for a two-week period. The child was usually

seen on a one-to-one basis for two or three days, getting to know the staff and taking individual tests. The child was then put into a group situation, and his behavior in group situations was noted.

While the child was being evaluated, the home facilitator (a teacher who would be working with the parents and child in the home) made a home visit. She gathered developmental history, further described the program and tried to ascertain if there were any major problems the mother was facing with the child at that time. If so, methods of dealing with those problems would be sought.

At the end of the two-week diagnostic period, the diagnostician wrote a prescription for the child. Areas that required more practice and specific tasks which needed to be learned were listed. Materials and methods that worked well for the child while he was in the center were noted in the prescription.

LEASE was the only preschool program visited that was exclusively home-bound. The program developers felt that three- to five-year-olds should not be required to travel long distances and they felt that classrooms for preschoolers were artificial situations. They perceived the home as a better place for the child to better adapt to his environment. In order to do this, two teachers, known as home facilitators, visited and worked directly with the children in the homes.

Before visiting the homes, the home facilitator conferred with the diagnostician to plan activities for the home visits. The facilitator also used a card file which was developed locally that contained representative tasks which could be expected of a child in a given age range. On each card, the task was named, defined, and the developmental levels given,

along with the procedure for evaluating a child's performance on the task. Also included on the card were activities for developing the skill and activities for practicing the skill.

The home facilitator visited the home daily for the first two weeks, spending one-half to three hours with the parent and child. Depending on the need and the readiness of the mother to implement the activities presented by the facilitator, the home visits became less frequent. She came to the home twice a week for a while, then once a week, then once every other week.

The parent was given a list of materials to collect. This list contained objects that could be readily acquired like egg cartons, old magazines, and empty cans. The intent was to show the parents that they did not need expensive toys in order to help their child. Everyday items from around the house could become perfectly adequate learning materials.

Staffings were held on many levels throughout the year. Two half-days each week the diagnostician and home facilitator staffed the children with whom they were working. Approximately twice a month, the project director-psychologist came to these sessions to provide advice on how to handle specific case situations. Whenever a child was placed in another agency program, the diagnostician and home facilitator of that child would meet with the new teacher. Staffings were also held with the teachers who were to have these children the following year.

Program successes included the following:

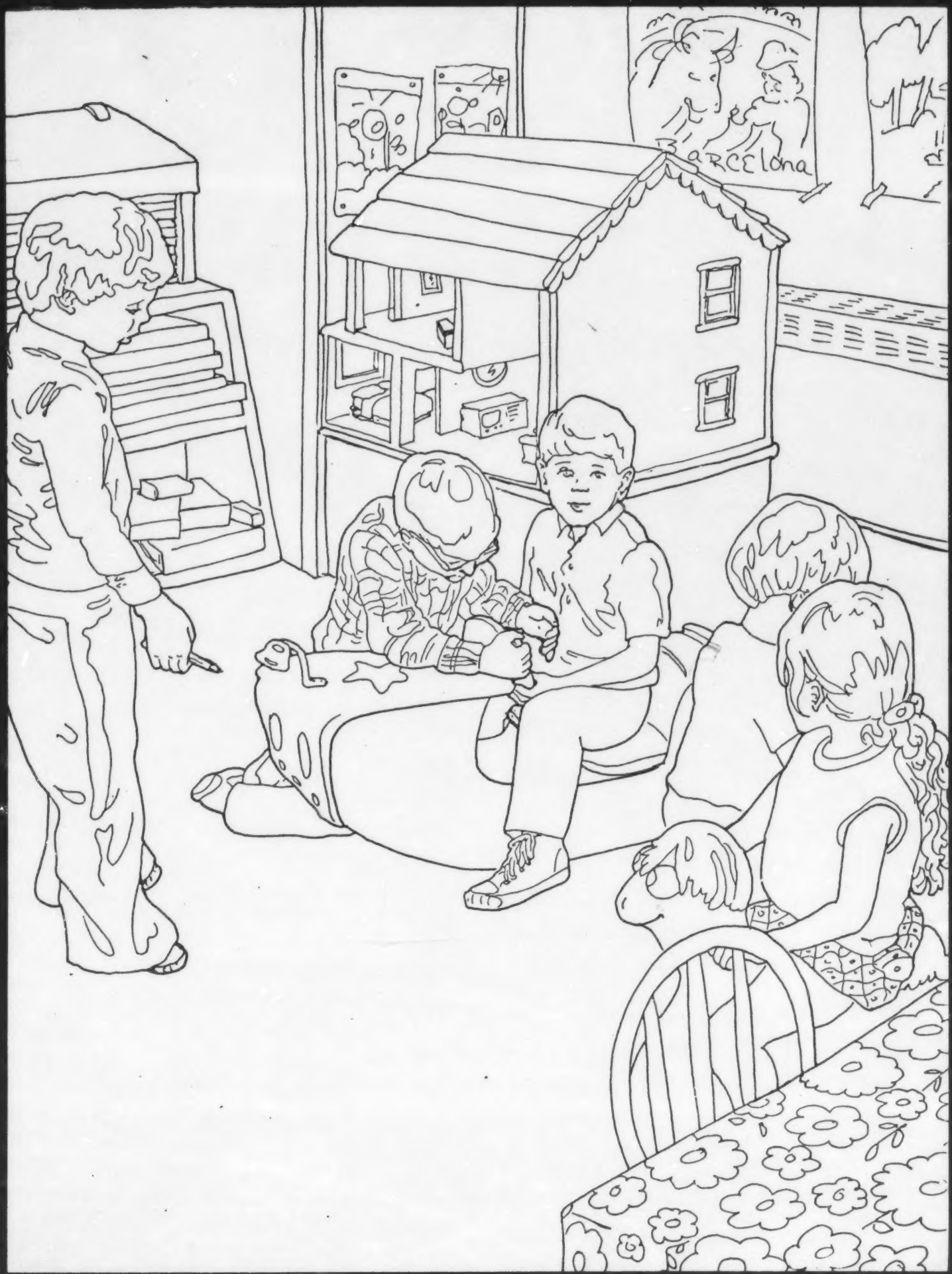
1. All of the children gained developmental skills.
2. There have been some family successes, i.e., families working out their problems together.
3. County superintendents who were skeptical of the merits of a preschool program now endorse the program. Consequently, the program will be expanded next year.
4. The kindergarten teachers are prepared for these children.

Program weaknesses included the following:

1. There was lack of communication and public relations to the general population. Many people are not aware that the program exists.
2. Eligible children were not always screened by local psychologists and therefore not enrolled in the program.
3. The designer of the program had not anticipated either the number or the depth of disturbed homes and families with whom the program would be working. Therefore, there was a lack of adequate assistance in these situations.
4. There was no psychologist consultant for the facilitators and diagnostician, so the project director occasionally provided this service.

Plans for next year include:

1. Hiring a part-time intern psychologist.
2. Hiring another facilitator.
3. Initiating a vigorous community awareness and involvement program to screen and provide follow-up services for all children needing them.
4. Conducting classes for parents.
5. Setting up a toy lending library.


Barcelona

Site and Location (#6)

Proviso Township Area
Department for Exceptional Children
1000 Van Buren Street
Maywood, Illinois 60153

Classrooms..... 1

Classes..... 2
(M W F - 3 hours,
T TH - 2 ½ hours)

Teachers..... 2
(Special Education
and Language Therapist)

Aides..... 2

Criteria for Eligibility

A handicap significant enough to potentially interfere with the child's progress in school and slow down his entire development if intervention was not forthcoming.

Screening and Diagnostic Staff

Four psychologists, two psychological interns, one language therapist, one early childhood specialist, one physical therapist, one diagnostician, one doctor.

Screening Instruments

1. Informal Physical Movement Test for Mobility and Range of Motion
2. Beery-Buktenica Test of Visual-Motor Integration
3. Observation of Linguistic Tests
4. Peabody Picture Vocabulary Test or other picture vocabulary tests
5. Stanford-Binet Intelligence Scale
6. Vineland Social Maturity Scale
7. Wechsler Preschool and Primary Scale of Intelligence
8. Myklebust Informal Inventory
9. Bender Motor Gestalt Test
10. Goodenough Harris Drawing Test

Diagnostic Instruments

1. Minnesota Preschool Scale
2. Slosson Intelligence Test
3. Basic Concept Inventory
4. Beery-Buktenica Test of Visual-Motor Integration

5. Stanford-Binet Intelligence Scale
6. Wechsler Preschool and Primary Scale of Intelligence
7. Vineland Social Maturity Scale
8. Detroit Test of Learning Aptitude
9. Peabody Picture Vocabulary Test
10. Myklebust Informal Inventory
11. Sentence Repetition Tasks
12. Illinois Test of Psycholinguistic Abilities
13. Goodenough Harris Drawing Test
14. Northwestern Sentence Syntactic Screening Test
15. Daily anecdotal records recording social, emotional, physical, educational, and language developments for each child
16. On-going diagnostic evaluation
17. Sociograms conducted periodically throughout the year
18. Home observations to compare with performance in the classroom setting

Referral Agencies

1. Proviso Area for Retarded Children
2. Proviso Mental Health Clinic
3. Cook County Department of Public Health
4. Loyola Clinic
5. Public School Social Workers, Nurses, and PTA's

Cooperating Agencies

1. Loyola University Medical Center
2. John J. Madden Zone Center
3. Proviso Township Mental Health Center in Melrose Park
4. Proviso Township Mental Health Commission in Westchester
5. Proviso Township Family Service
6. Proviso Association for Retarded Children
7. Maywood Community Health Center
8. Cook County Department of Public Health
9. Operation Headstart, Maywood
10. Operation Uplift
11. Office of Economic Opportunity Facilities in Maywood

The Proviso Township Area, Department of Education for Exceptional Children, covers the entire Proviso township area which measures 36 square miles in area and has a total population of 172,761 as of 1971. It is located just outside of Chicago and the township includes the communities of Bellwood, Berkeley, Broadview, Hillside, Maywood, Melrose Park, Stone Park, a part of Northlake, and a section of North Riverside.

The community was made aware of the preschool program through a variety of ways. A form letter was sent from the special education office to all superintendents and principals of Proviso Township, informing them of the preschool program in order to establish the channels for referrals of handicapped preschool age children. Feature articles were published in local newspapers informing the public of the new laws regarding preschool educational programs for the handicapped. Announcements were made on TV and all social service agencies were asked to cooperate.

Any child who was referred to the program was administered a battery of tests by a psychologist. The early childhood specialist assessed the child in his home, in his nursery school, in other low incidence programs, or in the diagnostic classroom situation. The language therapist evaluated the preschooler's language skills, so that an individual prescriptive language program could be established at home and in school, regardless of eligibility in the preschool program. The physical therapist observed the strengths and weaknesses for precise programming through classroom observation and administering of certain tests.

The goals of the program were outlined in detail in a booklet entitled Prepare, which was submitted to the state as their Title VI application. Every step of the program was planned out, with behavioral objectives stated for each staff member. As part of the behavioral objectives, 29 questions covering program strengths and weaknesses were asked and answered orally by the adult participants in the program at the final meeting of the year.

The preschool program was noncategorical and was based on the child's functioning level. There were two classes. One met on Monday, Wednesday, and Friday, for three hours a day; the other met on Tuesday and Thursday

for two-and-a-half hours a day. The teacher also worked with each child in his home for an hour each week.

The typical daily schedule was based on the following model:

8:15	8:45	Teacher Planning
8:45	9:00	Arrival of Students
9:00	9:30	Directed Play
9:30	9:50	Structure I -- Language Development
9:50	10:20	Snack and Bathroom
10:20	10:40	Structure II -- Cognitive Skills
10:40	10:55	Music
10:55	11:20	Art or Physical Education
11:20	11:30	Ready for Home
11:30	12:00	Teacher Evaluation of Day's Activities
12:00	1:00	Lunch
1:00	3:30	Home-Based Parent-Child Education

Individual objectives were specified in daily lesson plans. The teacher kept daily anecdotal records, noting behaviors, potential problems, and possible solutions. She used these records for inservice discussion and planned to include them in her final report.

The children were observed during the physical education period. While they were playing "Little Sally Saucer" in the gym, the teacher seemed to be very aware of all the children. When one child refused to participate in the game, the teacher and aide each held her hand and the three of them rejoined the group. The child continually dragged her feet, forcing the teacher and aide to pull her around. During one round of the game, another child came between the teacher and the problem child. Without assistance, the aide was unable to keep her in the circle. While the child was lying on the periphery of the circle, she was ignored. She got up and attempted to return to the circle. The teacher told her to take another child's hand, and from that point, the child voluntarily participated in the game. The teacher refused to let the children control her. She seemed sincere with the children, as she maintained a firm, yet pleasant, approach.

There was an aide for the M-W-F group and one for the T-TH group. The aides had assigned tasks that involved working with small groups of children and helping direct children in large group activities. The aides received feedback on their work during the planning periods after school.

The language therapist took children out of the classroom to work with them individually or in groups on vocabulary and sentence development. The younger children were taught in groups in order to get stimulation from each other, but the teacher tried to keep the groups no larger than four. She kept anecdotal records in order to plan future programs and to give feedback. She also recorded parent reactions to her sessions. She planned to use the records when assessing the children's progress at the end of the year.

When the classroom observation began, the language therapist had her materials ready for the children. She and the children sat on the floor. Her manner was relaxed and pleasant as she kept the children on task, requiring responses from them and praising them for good work. If they responded incorrectly or pronounced the word poorly, she modeled the correct word and had the children repeat the task. She remained very enthusiastic throughout the lesson.

Inservice meetings were held every Friday, and were attended by the teacher, the language therapist, and the diagnostician. Earlier in the year, they had held mini-staffings Later, they discussed behavior problems, compared notes, materials, discussed curriculum changes, shared ideas for the parent lending libraries and talked to salesmen.

The teacher and the language therapist observed each other and gathered data for feedback at the inservice meetings. The language therapist would sometimes observe parents in the observation room and discuss what she noted

with the teacher. The diagnostician observed the children's behavior through the one-way mirror. She and the language therapist would also observe the aides and provide feedback to the teacher.

The children were re-evaluated with the same measures that were used in September. The year-long evaluations based on anecdotal records were used at the staffing. They used a monthly ratio to measure growth, noting if the child gained three-months-in-two, or one-month-in-five. The children either remained in the preschool or were assigned to attend regular or special education classrooms in local districts next year. The children might be retested in the fall in order to measure the effect of the summer vacation on their performance. Local districts were to prepare for these children by visiting the center, observing the children, and meeting with the preschool team.

Parental involvement was a strong component of this preschool program. Parents were asked to participate in the classroom at least once a month, use the parent lending library, and attend evening parent group meetings. Home visits were made weekly by the teacher in order to demonstrate teaching techniques to the parents. The teacher, the language therapist, and the psychologist worked together to plan the parent program. Transportation for the child was not provided during the first few weeks of school in order to encourage the parents to come to the school. Parents observed the class for about a month before they began to participate. They helped teachers with learning tasks such as reading stories, completing art projects, listening to records, cooking and sewing, and they helped with play and snack time. Two fathers worked in the classroom and the staff planned to encourage more fathers to do likewise.

Another component of the parent program was the evening parent group meetings. There had been a good turnout at the two parent meetings where parents and teachers dressed casually in order to provide a more relaxed environment. Appropriate and meaningful programs were presented, parent concerns were clarified, and the prescriptive programs were explained.

Home visits occurred once a week. The parent remained in the room while the teacher worked with the child. During the 30-40 minute visit, the teacher and the child demonstrated activities from the classroom or worked on specific problem areas. The parent was encouraged to replicate the activities with the child.

The language therapist visited four homes where the children had speech problems. She encouraged the parents to work with the child on specific speech difficulties. She gave lesson plans to the mothers so they could see what was being done at school. Then she gave the mothers specific activities to do at home, or she showed the parents how to react appropriately to their child's speech problems. The speech therapist wanted parents in a structured involvement. She felt there were some things the therapist could do that the parent could not. She wanted to stimulate parents to relate better to their children, to work with their children, but not to overdo it.

The fourth component of the parent program was the toy lending library. The library had commercially made materials that the parents could check out and use with their children. The parents had to come in to check out a toy; it was not sent home. The teacher would sometimes use one of the toys during the home visit. Parents frequently checked out toys that they saw the teacher use with their child at home or at school. The speech therapist generally made her own materials, but she recommended similar kinds of games that the

parents could check out of the lending library. Parents were encouraged to create activities for their children or expand on ideas suggested by the teacher.

The teacher felt that most of the parents were working with their children at home. Her plans for the next year included cataloging the toys so that parents would know which toys could be used to help remediate specific problems.

Based on the 29 questions the staff had to fill out as part of their behavioral objectives, the following strengths and weaknesses were observed.

Strengths:

1. 100% parent involvement in the preschool enabled parents to become an integral part of their child's development.

2. A team approach enhanced the ability of the school to provide thorough educational services.

3. The positive behavioral approach used in the school and home helped parents learn new and productive ways to handle their children.

4. The two-room physical structure with two observation booths allowed visitors to observe without disrupting the classroom flow.

5. The unstructured, unsupervised play period observed from the observation booth by the teacher, psychologist, language therapist, diagnostician, and/or parents was highly beneficial in recording social and emotional growth of the children.

6. The parent lending library gave parents the opportunity to use toys that would meet their child's needs without the expense involved.

7. A highly structured behavioral and educational program set up by the diagnostician and preschool specialist taking into consideration each child's needs enabled the children to grow both academically and emotionally.

8. Because the pretests and posttests were utilized in a predetermined plan, the comparison allowed the team to assess each child's growth as well as to determine the feasibility of the tests used and the areas not formerly evaluated which will need to be included in the formal testing structure for 1973-74 school year.

BIRDS
INSECTS
12345

9. Home visitations enabled the preschool team to see the child in his home environment and observe how he reacted to conditions in the home.

10. Parent meetings enabled parents to meet other parents who had similar problems, to meet the entire team on an informal basis and learn to look beyond their child's problems to the educational concerns of all exceptional children.

Weaknesses:

1. In spite of a variety of efforts to inform the community about the preschool program, general knowledge about the program or an understanding of its purpose was not developed within the general population of the community.

2. More pre-set structures and forms need to be developed to clarify role and function of participants involved at any level in the preschool program, i.e., para-professional guidelines, parent involvement in the classroom, visitors' guidelines.

3. Parent lending library must be more specifically structured to meaningfully involve parents on a continuous basis regarding the selection and presentation of materials to their child.

4. Written lesson plans for the home visit should be complete previous to each visitation in order to help the parent be geared toward each lesson as an integral part of the formal program rather than a friendly visit with no specific goal in mind. Home visits should not exceed 30 minutes and should be consistently on time.

Site and Location (#7)

South Eastern Special Education District
Central School, 1307 11th Street
Lawrenceville, Illinois 62439

Classrooms..... 2
(Prescriptive
Diagnostic Room
and Classroom)

Teachers..... 2

Aides..... 1

Criteria for Eligibility

Inadequate functioning in sensory, affective, behavioral, motor, social, language or conceptual areas.

Screening Personnel

No formal screening during 1973 fiscal year.

Diagnostic Personnel

Psychologists, prescriptive diagnostician, learning disabilities teacher, administrator, audiologist, nurse, social or community worker.

Diagnostic Methods

1. Child observation at home, school, play (at home and school), under stress.
2. Illinois Test of Psycholinguistic Abilities
3. Peabody Picture Vocabulary Test
4. Psychological Testing
5. Purdue Perceptual Motor Survey
6. Frostig Developmental Test of Visual Perception
7. Slosson Drawing Motor Survey
8. Beery Buktenica Test of Visual-Motor Integration
9. Boehms Test of Basic Concepts
10. Goldman-Fristoe-Woodcock Test of Auditory Discrimination
11. Goodenough Harris Drawing Test
12. Ottawa Behavior Checklist
13. Visual Perception Checklist
14. Parent-Home Behavior Checklist

Referral Agencies

1. Illinois Department of Children and Family Services
2. Illinois Department of Mental Health

3. Illinois Department of Public Health
4. University of Illinois
   Division of Services for Crippled Children
5. Medical Personnel
6. Title VI ESEA
7. Private Agencies

Supportive Agencies

None Specified

The South Eastern Special Education District is a joint agreement that serves five counties (Clay, Crawford, Jasper, Lawrence, Richland) and 12 school unit districts. It is located in the southeastern part of the state, and the special education district serves a rural, sparsely populated area.

The eligible children were located by formal preschool vision and hearing screening and by a survey made by the Title VI staff of the local school districts and allied agencies. Parental questionnaire/letters were sent to the parents of all preschool and school children. Newspaper articles were also used to inform the general public of the initiation of the preschool program.

The testing and diagnosis for eligibility in the program occurred in the Educational Assessment and Adjustment Center (Prescriptive-Diagnostic Classroom). This diagnostic classroom was started during the 1971-72 school year, and was not considered part of the $10,000 Title VI grant. The objectives of the diagnostician were to render educational assessments and evaluations of preschool children and provide prescriptions to meet those children's needs. Once a prescription for diagnostically teaching a child was written up, the child was transferred to the early childhood classroom. The preschool classroom and the diagnostic center were located on the second floor of a school building in Lawrenceville, Illinois.

Among the facilities available were a conference room, an outdoor play area, a speech therapy room, and a gymnasium. Staff for the preschool included a full-time teacher, a full-time diagnostician, a full-time aide, and a language therapist twice a week for five hours a day. The following were on call as needed: two psychologists, one psychiatrict, an educational specialist, and an audiologist.

Children attended class five days a week; the average stay was three hours. An educational prescription was written for each child before he entered the preschool class. The teacher organized her program on the basis of the need areas defined in the prescriptions. Because the area was so rural, transportation schedules made the teaching schedule quite complicated. Three children arrived at 8:30 a.m. The teacher spent the first part of the morning doing individualized work, allowing the two children she was not working with to engage in free play. When she finished the individualized instruction, she took the children to the diagnostic room where they had snacks with other children in the building. After snacks, the children returned to their own room. At 9:30 a.m. another child arrived and the teacher did individual work with him. Around 10:30 a.m., there was more individual work followed by a group activity. Two children left at 11:00 a.m. Lunch was served at 11:15 a.m., and there was a noon recess. Another child arrived at noon and the last child arrived at 12:30 p.m. The teacher worked with these children individually while the others rested. The entire class then had story time followed by a group activity. They all went home at 1:45 p.m. One child remained at the preschool from 8:30 a.m. until 2:00 p.m.

Every day after class the preschool teacher would discuss the child with the diagnostician and the teacher of the emotionally disturbed. The

special education teacher used the Ottawa Behavior Checklist to evaluate the childrens' social skills. She kept anecdotal records, noting behavior problems and progress, and her reports were based on these anecdotal records.

The teacher was in charge of the parent program. She wrote notes home, visited the homes at least once, held a parent night, talked with the mothers when they picked up their children, met with parents about specific problems, and held end of the year parent-teacher conferences. She sometimes sent materials home for the parent to use with their child.

A speech therapist met with some parents two afternoons a week to teach them activities they could do with their children. These children were not in the preschool program since they only had speech problems.

Another teacher acted as a trouble shooter with the parents. She visited the parents of the preschool children and told them about their child's progress and provided moral support. She gave suggestions to parents, but did not set up a formal program that parents could implement in the home. She also looked for eligible children and acted as a substitute.

The psychologist attended parent group meetings and was available for individual parent conferences upon request. He also discussed the findings and recommendations with the parents.

Re-evaluation was based on compilations of additional medical, home and school information. Supplementary tests were administered; staffings and parent conferences were held. The preschool children were either placed in regular classes, special education classrooms, or retained in the preschool program.

Based on this year's experience, the administrator would have all children go through the Educational Assessment and Adjustment Center before entering special education classrooms or preschool classes, and he would expand the number of preschool classes.

The administrator of the program noted the following successes:

1. Each child made progress in one or more areas of training.

2. In individual cases, the intelligence quotient has increased from the trainable level to the educable level and from special class placement to regular class placement.

3. Parental attitude toward the child and the child's special needs has been altered to positive thinking.

4. A better line of communication has been established between the early childhood education class, Early Assessment and Adjustment Center, and the children's future teachers. Cooperation has also increased with the local school districts due to the early childhood class by tying the Early Assessment and Adjustment Center to them.

Problem areas that the administrator felt needed improvement were:

1. Transportation. He would like to have a morning and an afternoon group meeting for specified times.

2. Formal screening. He would like to initiate a formal screening program in order to find more eligible children.

3. Parental involvement. He would like to see more parental involvement. Direct training of the parents to teach their child at home and more parent group meetings were needed. Sparsity of population and distances involved made it difficult for parents to meet.

Site and Location (#8)

Tazewell-Mason Counties
Special Education Association
Pekin, Illinois 61554

Classrooms..... 1

Teachers..... 1

Aides..... 1

Criteria for Eligibility

1. Handicaps that would impede normal development, but would not hinder integration with normal children, especially lags in speech and language development, socialization, self-help, and pre-academic skills.

2. Parents who expressed interest in receiving help in working with their children at home.

Screening and Diagnostic Personnel

A social worker, a psychologist, a teacher, a speech/language therapist, and two nurses.

Screening Methods

1. DIAL (A state developed screening test)
2. Observations
3. Parent interviews
4. Referral and health information

Diagnostic Methods

1. McCarthy Scale of Children's Abilities
2. Wechsler Preschool and Primary Scale of Intelligence
3. Bender Motor Gestalt Test
4. California Preschool Social Competency Scale

Referral Agencies

1. Holiday School
2. Peoria Association for Retarded Children
3. Preschool Family Center
4. Public Health Department
5. Physicians
6. Optometrists
7. Title VI Regional Program in Peoria
8. Nursery Schools

The Tazewell-Mason Counties Special Education Association is located in Pekin, Illinois, across the river from Peoria, in the central part of the state.

The community was made aware of the preschool program through agency referrals and through contact with public school personnel. Parent meetings publicized in local newspapers, on radio, as well as publicity in the Special Education Association newsletter kept the community informed of the program.

The preschool program had two components. As one component, the seven children who were identified as handicapped attended St. Paul's Children's World, a private nursery school that cooperated with the Special Education Association. The children were provided with their own classroom, teacher, aide, psychologist and other staff services. By being placed in the nursery school, it was hypothesized that handicapped children would be allowed to interact with normal children in a controlled environment as well as have access to specific techniques designed to alleviate their unique problems.

The second component included an ongoing parent education program, with the special education staff assisting in setting up a parent child program in the home. It was hoped that the parent-training aspect of the program would provide 24 hour control of the child's learning environment and would help the parents to better understand their child and his relationship to others.

The children attended school two-and-a-quarter hours a day, five days a week. They were served directly by two psychologists who came in one day a week and worked with the children approximately four hours, a language therapist who came in half a day per week, an aide who was in the classroom daily and the teacher who was at the school every day and conducted home visits for one hour a day.

The nursery day care center served approximately 90 children. The children were grouped by age and maturity in classes of not more than ten. Activities in which the seven handicapped children participated with the other children included music, outside play, inside free play, water play, creative dramatics, and DISTAR, a direct instructional program in reading, language arts, and arithmetic. The amount of time each child spent with the regular nursery school group was determined by the child's individual needs.

Monday's and Friday's were art days, and the handicapped children worked in their own rooms as a homogeneous group. They also participated in fine and gross motor activities on these days. Tuesday's and Thursday's the handicapped children moved in and out of the other classrooms, being instructed in reading, language or arithmetic, or they remained in the special education room, receiving individualized instruction from the teacher.

The teacher had general objectives written down for individual children. She was observed working with two children on language concepts using cut-outs that had matching scenes and characters such as a castle, king, queen, knight or a rocket ship, moon, and astronaut. Later, these children left the room to attend an instructional session with the other regular nursery school children and the teacher worked individually with another child, who had returned to the home room, in arithmetic.

The aide assisted the teacher by doing supplementary work with the children such as counting, puzzles, and sequential cards. She also observed and helped maintain order in those rooms in which the handicapped children were getting group instruction. The aide provided feedback to the teacher about how the children were progressing in the other instructional sessions, and the teacher and aide planned objectives based on their observations.

The teacher used anecdotal records to keep track of educational gains, socio-emotional growth and improvements in motor ability. She also used a checklist to note when a child mastered a particular skill.

Combined inservice meetings and staffings were held twice a month. The teacher, the chief psychologist, the intern psychologist, the social worker who worked with parents, the communication therapist and the early childhood coordinator attended these meetings.

The progress of the children were discussed along with ideas for future work with the children. Children were re-evaluated on a continual basis; the final re-evaluation for placement was based on pretests and postests, teacher/staff evaluation, and the child's behavior in the home.

The parent program was to have two components. The first compotent would be afternoon home visits by the teacher, the intern psychologist, and the social worker on the average of once a week. The teacher would help structure the home environment so that the parents would be able to work more effectively with their children.

The social worker would interview the parents before the child entered the program, and also be involved in home intervention. The intern psychologist would help modify specific behavior in the home. Students in the graduate seminar in school psychology from Bradley University would be available to work with children and parents in the program under supervised conditions. Specific instructions designed to help each parent in molding behavior in their child would be provided by the teacher, social worker and intern psychologist.

Target behaviors were:

1. Self-help behaviors: feeding, dressing and undressing, toileting responsibility.

2. Social behaviors: following directions of parents and teacher, verbalizing appropriately, relating to peers in group activities.

3. Pre-academic behaviors: matching and naming common colors, objects and forms, recognizing basic number concepts, attention to pre-academic tasks.

Strategies were to be developed to teach the parents how to deal with their particular problem. After training, it was hoped that parents would be able to utilize child management techniques in the home, and that the parents and teachers would become an effective team in assisting in the development of appropriate behaviors in the child. It was also hoped that after training, the child would improve in the areas of play, speech skills, locomotor activities, toileting, peer interaction and pre-academic abilities. Each objective was to be evaluated by comparing pre-intervention functioning with post-intervention functioning.

The structured home visitation program did not work out as planned. Rather than meeting with the teacher, the social worker and the intern psychologist, the parent met with only one of the three. It was felt that too many professionals would hinder progress with the parents. The graduate students were not utilized for the same reason.

Attempts to set up structured environments and schedules in the home were unsuccessful. The staff was unable to get sufficient parent cooperation in order to implement the behavioral change program as planned. Instead, the teacher or intern psychologist or social worker would visit the home once a week, or once every two weeks, and would discuss the child's progress in school and how the parent could reinforce what was taught in the home. Methods for modifying a child's behavior in the home were suggested and the psychologist would bring books the parents could read.

The second component of the parent program was monthly parent meetings. At these meetings, attempts were made to help parents understand the child's problems and their own feelings about their child's disability. The coordinator also met individually with parents to discuss specific behavioral problems and offered behavioral programs to eliminate these problems.

Of the seven children who took part in the project, one was enrolled in first grade with learning disability services and three went to kindergarten, with supplementary services provided by the school. Three of the children remained in the early childhood program.

In the year-end evaluation, all involved personnel felt that the project had been a success. A continuation of this type of program is planned for the 1973-74 school year with the same professionals being involved as well as the addition of a second classroom and teacher.

The Three Bears

Site and Location (#9)

Wabash and Ohio Special Education District
Route 460 West
Carmi, Illinois 62821

Classrooms..... 1

Teachers..... 1

Aides..... 2

Criteria for Eligibility

Any child from three to five with problems that might handicap learning.

Screening Personnel

One nurse

Screening Methods

1. Preschool vision and hearing screenings
2. Checklists completed during home visits
3. Signing of Parents' Consent Form allowing doctors and social agencies to release information about their child.

Diagnostic Personnel

One teacher, two aides, five psychologists, one physical therapist, one speech/language therapist, volunteer parents.

Diagnostic Methods

1. Columbia Mental Maturity Scale
2. Beery-Buktenica Test of Visual-Motor Integration
3. Illinois Test of Psycholinguistic Abilities
4. Peabody Picture Vocabulary Test Kit
5. Preschool Attainment Record
6. Preschool Language Manual
7. Purdue Perceptual Motor Survey
8. Slosson Intelligence Test Kit
9. Vineland Social Maturity Scale
10. Wepman Auditory Maturity Scale

Referral Agencies

1. Department of Children and Family Services
2. Public and private school personnel
3. Nursery schools
4. Day care centers
5. Local public schools

6. Department of Mental Health
7. Bowen Center
8. Anna State Hospital
9. Division of Services for Crippled Children
10. Easter Seal Society
11. Physicians
12. County school nurses

Supportive Agencies

None Specified

The Wabash and Ohio Special Education District is located in southeastern Illinois. It includes nine counties: Edwards, Gallatin, Hamilton, Hardin, Pone, Saline, Wabash, Wayne, and White, and is the largest joint agreement, in area, in the state. However, the school population (K-12) is less than 22,000.

Eligible children were located through preschool vision and screenings and through referrals from various agencies. Letters were sent to all schools in the joint agreement and notices were published in local newspapers. Superintendents of local schools informed their school boards of their responsibility to locate these children. The district did not have any method for seeking children unless they were referred through an agency or a medical person.

When a child was referred, letters were sent to the parents, and a home visit was made by the nurse. She completed checklists during the home visit and the parents signed a Parents' Consent from allowing doctors and social agencies to release information about their child.

This particular project was unique, because a year-long preschool classroom did not exist. Children attended what was called the Educational Assessment Room for six weeks to three months. During this time they were observed, diagnosed, given learning prescriptions and sent back to the home school district for placement. Since local districts did not

have classrooms, the children did not receive further formal instruction. During FY 74, six of the nine counties plan to have one classroom while another county will have two classrooms.

The Educational Assessment/Adjustment Center (as the diagnostic room was labeled) had the full time services of a special education teacher who was an assessment specialist; she administered the battery of tests, planned and prepared materials and prescriptive programs, as well as directed and carried out home and follow-up visitation. Assisting her were two teacher aides who prepared materials, recorded results and followed the teacher's individualized instructions for the child. Five psychologists and one physical therapist were on call when needed. A speech/language therapist came one day a week for two to five hours, and parents came to the classroom occasionally to read stories, bring cookies during milk break, or help during the play period.

During the first three quarters of the academic year, the children came for three-and-a-half-hours a day. Later, they were divided into two sections that met two hours a day, four days a week.

Each child was provided with individualized instruction during a flexible daily schedule that had a varied routine, lasting for short periods. The child was given tasks where he could be successful and various methods of remediation were used. Tasks were taught to criterion. Remedial activities included music, story, dramatics, art, games, and physical exercises. Testing of strengths and weaknesses through individualized instruction occurred all morning. Music, art, and story were presented at the beginning or the end of the day. "Show and Tell" and conversation occured during snack.

Inservice for teacher and aides was held at least once a week. The teacher provided direction for the aides and instructed them in the use of behavior modification techniques. Sometimes the psychologist or the director attended. They discussed the progress of the children, the effectiveness of the program and possible schedule changes. The aides assisted the teacher in teaching, planning, diagnosis and working with the parents. The aides followed the teacher's instructions and gave her input on the children's progress. She, in turn, would provide input for the aides by suggesting alternative methods for working with the child. One aide was hired to do most of the paper work, such as typing up anecdotal records and prescriptions, but she found that she was doing much more teaching than she expected, and she enjoyed it.

The classroom was located in a two-room house adjoining a grade school. It formerly served the kindergarten classrooms. The rooms were wood paneled, had chalk boards, a house corner, cooks, materials, a sand table and other preschool equipment.

During a classroom observation, the teacher and aides divided the children up. The aide worked with two children on picture identification, speech sounds, color, and matching animal sounds to pictures of animals. The teacher worked with one child on drawing shapes. Since the child couldn't make a cross, the teacher guided her hand while providing a lot of positive reinforcement. The teacher also worked on matching shapes. The second aide worked with a child on pop-it beads and piling shapes into matching holes. Cognitive activities went on continuously all morning.

The teacher kept anecdotal records to note rates of learning, to compare the child on pretests and posttests, to determine cultural influences on

problems, and anything else she might find pertinent to the child. She administered a checklist after the first or second week and again as a posttest. Children were re-evaluated through pre- and post-standardized and teacher-made tests, teacher/staff evaluations, behavior in the home, and classroom observation data. From these, the prescriptions were written.

From the time of the first visit by the school nurse to the home and throughout the child's participation in the diagnostic class, parents were to be informed of and encouraged to be involved in the planning and development of the child's program.

Parents were to be involved through:

1. Teacher-parent conferences before the child entered the program and during his stay
2. Home visits
3. Class observations
4. Parent groups
5. Active parent participation in class
6. Follow-up parent interview questionnaire after child leaves the program

The teacher held conferences with the parents when the children entered the program, and whenever she felt conferences were necessary. Two parent group meetings had been held as of May and the director of special education, the teacher and the psychologist attended. However, there was limited parent response; only two couples came to the second meeting.

The teacher and one of the aides conducted home visits to observe the child in the home and to demonstrate teaching techniques with the child; she discussed her methods with the parents. The aide went on home visits alone, offering suggestions for parents based on what the teacher recommended.

The parents were shown how to make learning materials and were given ideas for games and worksheets. The parents also participated directly in the classroom. They observed their own child and engaged in activities such as reading stories to the children.

Program successes included the following:

1. Measured progress of each child.

2. Cooperation and involvement by nearly all the parents (22 of the 23 parents became involved in some way).

3. Awareness of individual student's needs by several of the school districts and attempts to acquire services to meet these needs, e.g., a speech therapist.

4. Provision of adequate transportation by most school districts.

The program personnel felt the program could have been improved if:

1. They had a speech/language therapist once a week on a continuously rotating basis in order to observe the child's adjustment to another person and to provide more thorough support to the classroom teacher.

2. The physical therapist had had more experience with special populations.

3. Parent participation in the classroom had begun earlier. Participation gave the parent an awareness of the child in relation to others.

4. All the eligible preschoolers had been located. Many school superintendents were observably slow or simply did not complete the necessary referrals.

5. Classes or follow-up services had been provided by local districts for the children after they had attended the diagnostic center.

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Site and Location (#10)

West Suburban Special Education District
1225 60th Court
Cicero, Illinois 60650

Classrooms.....1

Teachers.....2
(one taught in the morning,
one in the afternoon)

Aides.....4

Criteria for Eligibility

Children previously labeled educable mentally handicapped, trainable mentally handicapped, socially maladjusted, learning disabled, or emotionally disturbed.

Screening Personnel

Psychologists, teachers, speech and language therapists, pediatricians, and social workers

Screening Methods

1. Parent interviews
2. Review of referral information
3. Speech and language evaluation

Diagnostic Personnel

Psychologists, teachers, speech and language therapists, pediatricians, psychiatrists, optometrists/opthamologists.

Diagnostic Methods

1. Wechsler Primary and Preschool Intelligence Scale
2. Sections of the Merrill-Palmer Scale of Mental Tests
3. Sections of the Grace Arthur Point Scale
4. Vineland Social Maturity Scale
5. Bayley Scale of Infant Development
6. Classroom observation

Referral Agencies

1. Pediatricians
2. Nursery Schools
3. Churches
4. Park district and recreation department programs
5. Department of Children and Family Services

Cooperating Agencies

None Specified

The community was made aware of the program before it began through editorials in local newspapers, information on kindergarten registration forms, PTA meetings, nursing services, park district recreation programs, local medical personnel and Department of Children and Family Services. Continuing information was made available through newspaper feature stories, PTA meetings, presentations to public concerning the program, and inservice training for school personnel.

Screening and identification programs were initiated by contacting community agencies and facilities that might be aware of handicapped preschool children. Referrals went to local school principals for registration, confirmation of birthdate and school district residence. Extensive information concerning social, emotional, physical and intellectual development of each child was obtained and evaluated. Parents completed a family history form and participated in home interviews during which the social and emotional development of their child was discussed. A medical examination was secured and each child was evaluated by the psychologist after the parents signed a written consent. Past records were obtained from cooperating agencies that had worked with the child previously. Eligible children were evaluated through anecdotal records noting gross and fine motor abilities during a trial classroom placement, during small group sessions, outdoor play, and free play periods. Activities such as toileting, eating, resting, following directions, attending to the teacher

during instruction periods, and attending to materials in order to complete a task were noted.

Following complete evaluation and staffing, children were:

1. accepted into the preschool program,
2. referred back to the local district for specific services such as speech therapy or,
3. were declared ineligible for the preschool program, but the parents were provided with assistance in placing the children elsewhere.

The children met five days a week for two-and-a-half hours a day. There was a morning group and an afternoon group, each with a different teacher and two aides. The teacher/pupil ratio was 1 teacher and 2 aides to 12 children. Facilities included a kindergarten room with an adjoining observation room, a conference room, an outdoor play area, a speech therapy room, a parent lending library, and a physical therapy room. Staff included two psychologists on a contractual consultation basis, one speech/language therapist, one physical therapist, one physician/pediatrician, a volunteer a week, and optometrists/opthamologists contracted on a consultation basis. Local district personnel were utilized as much as possible.

Behaviorally stated cognitive objectives were written for each child along with generally applicable behavioral objectives in the areas of affective behaviors and psycho-motor skills. The organization of materials and teaching strategies was described in behavioral terms with step-by-step progressions to be used in achieving the objectives. The following was typical of a daily schedule:

8:00 - 8:45 Planning session. Teachers review lesson plans, objectives for children, and daily schedules. Materials to be used that day are organized.

8:45 - 9:00	Arrival. Children arrive and are individually greeted by a teacher. Self-help skills emphasized (removing outer clothing, toileting, handwashing).
9:00 - 9:20	Perceptual-Motor Activities. Children are free to select from puzzles, form boards, cylinder blocks, stacking rings, self-help boards, and books. Language concepts are reinforced by labeling, describing, questioning, and listening.
9:20 - 9:35	Small Group Activity. Children meet with teachers (one to four children per teacher) for language development, math readiness, or social studies.
9:35 - 9:55	Snack. Toileting, handwashing, setting table, preparing food. Emphasis on spontaneous conversation, language development.
9:55 - 10:00	Clean-Up. Prepare for outdoor activities.
10:00 - 10:25	Physical Activities. Playground activities are integrated with and reinforce the child's total educational day.
10:30 - 10:50	Small Group Activity. Language development, math readiness, or social studies and sciences.
10:50 - 11:15	Music. The entire group participates in songs that teach basic concepts and in auditory discrimination activities using simple rhythm instruments.
11:15 - 11:30	Perceptual Motor Activities: Language Stimulation. In addition to activities mentioned above, children select from blocks, a housekeeping corner, and art activities (including cutting, tearing, pasting, painting, and clay). Departure. Children put on coats and nametags. Teachers accompany them to waiting taxis.

The curriculum was based on the Illinois Test of Psycholinguistic Abilities model for working with handicapped children, and developmental guidelines both formulated by Dr. Merle Karnes at the University of Illinois. Both preschool teachers had worked with Dr. Karnes at the university.

Individual objectives were written down for each child. One teacher wrote lesson plans to meet individual needs while the other wrote lesson plans for the group which included notes about individual children.

Every day, 45 minutes to an hour before class, each teacher and her two aides reviewed the day's schedule. They discussed the lesson plan and objectives of the day for each child. After their respective classes, both teachers discussed what happened with the aides. One teacher talked over progress and problems, while the other teacher kept a daily anecdotal record noting how the children handled various tasks, if they reached criterion on skill mastery or any other significant event.

The aides were involved in teaching and planning. Neither teacher felt she was able to supervise her aides unless attendance was poor; then the teacher could observe the aides in the classroom or through the one way mirror. One teacher would alternate groups with the aide so that she could remediate any gap that might be developing. The other teacher answered any questions posed by the aides. All the aides got feedback on their performance during the evaluation period after class. One teacher had her aides describe events during the day, and then they discussed if the aides handled the situations appropriately. Alternative methods for dealing with a variety of situations were discussed. This teacher and her aides also used a rating scale they developed to use on each other when classroom attendance was poor. When she could observe the aides, the other teacher would ask them how they could improve in an area. Then she would suggest alternative methods for handling the situation.

Both teachers were involved in the staffings that determined placement. Staffings occurred at the end of the year to determine placement for next year. The children were placed in regular kindergartens, primary learning disability classrooms, primary educable mentally handicapped classrooms, primary trainable mentally handicapped classrooms, or they continued in the preschool program. Staffings were held with receiving teachers and all reports, class work, test information were forwarded to the teacher.

The parent program was handled by the preschool teachers and had two goals:

1. Direct training of the parents to teach their child at home and,
2. Group or individual counseling. Each teacher's non-teaching time was to be devoted to the parent program.

Every month, the parents met as a group. During this time, the classroom programs were interpreted by the teachers, educational devices were suggested, materials were made for home use, observation time in the classroom was scheduled, and the parents exchanged ideas and feelings about their children's progress at home and in school. They were encouraged to check out materials to use with their children from the home lending library.

Home visits were also made by the teachers on a regular basis. The teacher discussed home lesson plans that showed the parents how to remediate specific deficits. Materials that could be used from the home lending library were suggested. Parents were asked if there were areas of development they were concerned about, and parents noted improvement areas.

Further parent involvement occurred through classroom observation scheduled once a month for each parent. They observed the children and took data, and they also worked directly with the children under the teacher's supervision. They helped by reading stories, assisting in art projects, pasting, and helping children perform fine motor tasks like stringing beads.

A discussion group was held every Thursday night for interested parents. They met with a psychologist to discuss problems in raising a special child. This discussion group developed when the teachers found that the parents tended to use the home visit time as therapy sessions. Rather than discuss the child's progress, the parents often wanted to discuss their personal problems. It was hoped that the Thursday night sessions would help those parents.

Next year, the school psychologist plans to work with the teachers in making suggestions for home follow-ups and also plans to do individual consultations with the parents.

Based on this year's experience, the program administrator would use more teacher time in full day teaching assignments after they became familiar with the parents and their needs.

Parental Involvement at the Ten Sites

Parental involvement at the ten Title VI sites varied from no involvement to substantial participation. For some parents, contact with the teacher occurred only when the mother or father picked up the child. For others, there were weekly meetings with school staff, weekly visits to the home by teachers or actual teaching experience in the early childhood classroom.

Of the 28 parents interviewed, 10 learned about the program through various public school staff members. Three contacted their local school districts after learning about the passage of House Bills 322 and 323. Seven families were referred to the local schools from diagnostic clinics, Easter Seals, an eye doctor, and the health department. Others heard about the program by word of mouth.

The most frequent reasons given by the schools for placing the children in the program were: to improve language and speech development, to help the child reach his potential, to help the child relate to his peers better, to improve physical coordination, and to remediate or resolve problem areas before the child reaches kindergarten. Two parents stated that they were not told the purpose of the program and one parent could not remember the purpose.

Contacts with school personnel ranged from daily to once. Those who saw the teachers daily were parents picking up their children after class. They would frequently stop and talk to the teacher about their child's progress. Some of the schools had weekly home visits as part of their total program. Parents involved in these programs would see the teacher every

week, and would observe the teacher teach the child a concept. These parents were expected to practice what the teacher did, so they could teach their children at home. One community held weekly evening meetings conducted by the school psychologist to discuss problems in the home. Of the 28 parents who met with staff members, 24 also met with teachers. When they met, teachers and parents discussed the child's progress, problem areas and concepts to reinforce at home.

In 14 of the 28 families interviewed, only the mothers were involved in working with the handicapped child. Husbands and wives were involved in the other 14 homes along with siblings in 2 families and grandparents in 2 families. One program had fathers as well as mothers teaching in the classroom.

Home visits were made by teachers or other staff members to 21 of the 28 homes of parents interviewed. The staff, mostly teachers, observed the child at home, worked with the child at home, discussed progress, or offered suggestions of activities to do at home. Some of the teachers called the parents to discuss the child's progress rather than visit the homes.

All the parents, regardless of the program, felt that what the school was doing was "great", "wonderful", "fantastic". They felt their children were being helped and they were glad they were living in an area that provided such services. Three provided comments that reflected local problems. Two mothers felt that the class size was getting too large, and another felt she had the right to know more details about her daughter's condition. She resented her child's prescription being kept confidential, and she finally convinced the superintendent to make portions available to her and to parents of children enrolled next year. She wanted to form a parent group for parents of retarded youngsters, but she was receiving resistance from the local school districts, who refused to divulge the names of eligible parents.

Twelve of the parents, at the time of the interview, did not know where their child would be placed the following year. Seven thought their children would remain in the early intervention classroom; five thought kindergarten; one, an EMH classroom; one, a special education classroom for handicapped; one, attending a parochial school, and one, receiving speech therapy.

CHAPTER 3

CONCLUSION

The Early Childhood Special Education Survey revealed valuable information which may be useful to the State Office of Education (SEA) in planning and developing legislation. The SEA is now aware that approximately 23,876 prekindergarten children were screened during the 1972-73 school year, while only a projected figure of 20,086 is proposed for screening during the 1973-74 school year. Of the various screening instruments used by the districts, OSPI's DIAL appeared to be the one instrument most frequently administered by the approximately 1400 professionals and 1000 volunteers who participated in the process.

Unfortunately, the survey form did not request the number of children who were diagnosed after the screening process. However, the number identified as potentially handicapped after diagnosis was 4077.

There were a variety of individuals involved in the diagnostic procedures. A point worth noting here is that a large number of pediatricians were used in the diagnostic procedures and a significant increase is indicated for the 1973-74 year. However, this could indicate a referral system rather than direct involvement. Medical evaluations, formalized psychological evaluations, home interviews and observations were the most frequently used diagnostic procedures for the 1972-73 school year. There was a slight decrease in the projected number of medical evaluations for the 1973-74 school year.

Of the total 4077 children identified as handicapped or potentially handicapped, a total of 1524 prekindergarten children were served during the 1972-73 school year. Almost twice as many physically limited children were served as compared to the number of developmentally delayed. Althought the projected figures for the 1973-74 school year indicate there will be a slight decrease in the number of physically limited who will be receiving services, the data from the survey also indicates that the number of developmentally delayed children receiving classroom services will more than double during the 1973-74 school year.

In the projected figures for the 1973-74 school there will be a high number of speech and language clinicians and learning disability teachers who will be involved in providing services, while the number of teachers for the physically handicapped will decrease for the 1973-74 school year.

There were ten sites in the state that provided services for these handicapped and potentially handicapped children and subsequently were chosen to receive Title VI funds for three purposes. First, the monies were to assist the sites as they initiated, developed, and expanded early childhood education programs. In this capacity, the funding was effective. A second purpose was to identify demonstrable programs on a fairly equal geographic distribution throughout the state that offered services to three-year-old children. As evidenced by the site locations, this too, was successful.

A third purpose was to disseminate information by making the sites' programs available for observation by visiting teachers and administrators. In this capacity, the sites were not very effective. Special education directors were informed of these sites and their locations at the October, 1972 convention for the Illinois Council on Exceptional Children. Special

education directors also received memos from OSPI in late October, 1972, describing the nature of the pilot observation projects and their locations. This information was repeated again at state sponsored early childhood workshops that were held in various geographic areas. In spite of dissemination efforts by OSPI, only a minute number of local special education staff visited the sites.

Even though the ten sites were extremely limited as pilot observation projects, it is hoped that this report, with its detailed descriptions of the programs at these sites, will serve as a dissemination vehicle. It is anticipated that people reading this report will be informed about various methods being utilized in Illinois for educating preschool handicapped children and will contact the various sites for further details.

SECTION II

RESEARCH COMPONENTS OF EARLY CHILDHOOD INTERVENTION

CHAPTER 4

REVIEW OF EARLY INTERVENTION STUDIES

Studies Justifying Early Intervention

The rationale for early education of the handicapped child is based upon the premise that by mediating disabilities while the child is very young, the child's opportunities to develop intellectually, physically, and emotionally and to lead a rewarding life will be enhanced. This does not imply the disability will be removed or that it will not effect development, but this premise does imply that the effects of a handicapped condition can be minimized so that it takes a secondary role in the child's development.

A survey of the current literature indicates that the rationale behind early intervention rests basically on three studies. In one study, Skeels and Dye (1939) arranged an experiment in which retarded adolescent girls, residing in an institution for the feeble-minded, cared for 13 babies who were failing to thrive in an orphanage environment. This study was based on a "clinical surprise"[1] in which two infants, one aged 13 months with a Kuhlman IQ of 46 and the other aged 16 months with an IQ of 36 were transferred from a state orphanage to a state institution for the

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1 J. McVicker Hunt, "The Psychological Basis for Using Preschool Enrichment as an Antidote for Cultural Deprivation" in Preschool Education Today, ed. by Fred M. Hechinger, (Garden City, New York, Doubleday and Co. Inc., 1966) p 53.

feeble-minded where they were cared for by 14-year-old girls who were somewhat brighter than the average patient. Approximately six months later, a psychologist noted a marked improvement in the infant's behavior. When retested on the Kuhlman scale, the younger infant scored 77, and the older one scored 87, an improvement of 31 and 52 points respectively, within half a year.

The 13 children who were used for the experiment were about 19 months old and had a mean IQ of 64. They were compared with a group of 12 infants averaging 16.6 months of age and having a mean IQ of 86.7, who were still residing at the institution. The children in the experimental group had a one-to-one relationship with an adult who provided love and affection and had a lot of attention and experimental stimulation from many sources. Over a span of 2 years, the experimental group showed an average gain of 28.5 IQ points and the control group lost an average of 26.2 IQ points. A follow-up study, two-and-a-half years later, showed the control group still lagging, while 11 of the 13 children in the experimental group had been placed in adoptive homes and had maintained their earlier gains in intelligence.

Thirty years later, Skeels (1966) sought out the original subjects to determine the long term effects of his study. He found that the two groups had maintained their divergent patterns of competency into adulthood. All 13 children in the experimental group were self-supporting and independent, while 4 members of the control group were still wards of institutions and another child had died in adolescence at a state institution for the mentally retarded. The median educational level of the experimental group was grade 12, with 4 of them completing 1 or more years of college, while the median educational level of the control group was less than grade 3.

Another study frequently cited was completed by Kirk (1958). He studied the development of some 81 retarded children between the ages of 3 and 6, with IQ's ranging from 45 to 80. In the experimental group, 28 children living at home attended a special nursery school, while 15 children resided in an institution for the retarded and attended a nursery school operated by the institution.

The control group consisted of 26 retarded children living at home who did not attend nursery school and 12 institutionalized retarded children who received no extra enrichment. Seventy percent of the children who received preschool training showed IQ gains, ranging from 10 to 30 points, even though half of the children were classified as organically retarded, while the IQ's of the control group dropped. The gains shown by the experimental groups were maintained for several years.

In commenting on his own data and the work of other researchers who attempted to produce changes in the developmental rate of retarded children, Kirk (1966) suggested that greater gains can be expected if the enrichment is begun earlier. None of the known studies that began enrichment programs as late as age six, produced gains as large as those of either Skeels and Dye or Kirk.[2]

The third most quoted study was written by Bloom (1964). By studying all the available data published from a number of major longitudinal studies carried out over the last half century, he attempted to relate growth curves of various human characteristics to the influences of early experiences as

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[2] Betty M. Caldwell, "The Rationale for Early Intervention," Exceptional Children, Vol. 36, No. 10, (Summer, 1970), p 722.

well as to various theories of development. His main concern was identifying periods during which the characteristics under study were relatively stable and periods during which they were unstable and showed rapid change. Bloom concluded that "the introduction of the environment as a variable makes a major difference in our ability to predict the mature status of a human characteristic."[3] He suggested that environment will have relatively more impact on a characteristic when that characteristic is undergoing relatively rapid change than when relatively little change is likely. Bloom suggested that "in terms of intelligence measured at age 17, about 50% of the development takes place between conception and age 4, about 30% between ages 4 and 8, and about 20% between ages 8 and 17."[4]

It would appear from the literature that the period of about 18 months to 3 years is the time when significant differences in cognitive level and style begin to appear between children from differing cultural backgrounds, and that remediation begun after age 6 is less effective than intervention during the preschool years. While we cannot pinpoint the initial periods of learning readiness, there is a period between three- and four-years-of-age which roughly coincides with Jean Piaget's "pre-operational stage," where Martin Deutsch states that organized and systematic stimulation, through a structured learning program, might best prepare the child for the more formal and demanding structure of school. He

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[3] B.S. Bloom, Stability and Change in Human Characteristics, (New York, Wiley, 1964) p 184.

[4] Ibid., p 88.

feels that there is far less to be compensated for at this age when the more complex and less adaptable child reaches the first grade.[5]

Dr. Merle Karnes (1969) compared the effects of her cognitive intervention program initiated with three year-old's to her program initiated with four-year-old's. She found no significant differences between the progress made by three-year-old's and the four-year-old's after a one-year intervention. Weikart (1967) also failed to find significant differences when he compared intervention at three with intervention at four. However, after he applied the concepts of intellectual development devised by Piaget to his curriculum (Weikart 1969), substantially higher IQ gains and language gains were made by the three-year-old's over the four-year-old's.

Head Start

The focus of early intervention has been on disadvantaged children, and research on handicapped preschool children is not readily available. Since nationwide, the large majority of children in special classes for the educable mentally handicapped are from low income homes, and since there are more physical problems among low income children,[6] studies done on disadvantaged children should be applicable to the handicapped.*

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[5] Patricia G. Adkins and Carl Walker, "A Call for Early Learning Centers," Academic Therapy, Vol. VII, No. 4, (Summer, 1972) p 448.

[6] Merle B. Karnes, "Structured Cognitive Approach for Educating Young Children: Report of a Successful Program," National Leadership Institute Teacher Educational Early Childhood, the University of Connecticut Technical Paper, (Storrs, Connecticut, April, 1972) p 11.

* However, the long range effect of parental involvement may be quite different since parents of handicapped children may not be disadvantaged or handicapped in any way.

Operation Head Start began in 1965 and had as its premises the following:

1. Intelligence is not fixed at birth.
2. It grows in interaction with the variety of stimulating objects and circumstances which are present in the young child's environment.
3. Just as much growth occurs between birth and 4 as between 4 and 17 -- thus the preschool years are more influential than the elementary school age.
4. The "critical time" for cognitive growth, plus the critical place -- a stimulating environment -- produce the theory that the home -- or an "enriched" substitute for it, the preschool -- is more influential than the elementary school.[7]

However, the first survey of Head Start in 1966 found "a preference for a supportive, unstructured, socialization program rather than a structured, informational program.[8] The priorities set up by four out of five directors included:

1. attention to family needs since the family affects the child,
2. a friendly environment for the child,
3. attention to physical needs, and
4. socialization.

These priorities did not match the national ones, and in April, 1969, the Westinghouse-Ohio national evaluation of Head Start, called for by the Office of Economic Opportunity stated that Head Start had failed in its goals. It said:

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[7] Stanley H. L. Chow and Patricia Elmore, Early Childhood Information Unit Resource Manual and Program Descriptions, San Francisco (Far West Laboratory for Educational Research and Development, 1973) p 11.

[8] Ibid., p 11.

1. Summer Head Start programs do not lastingly improve children's learning or their attitudes about themselves or toward school.

2. Year-round programs do not seem to influence the development of positive attitudes. They produce some measurable but not impressive increases that last through grades one, two and three.

3. Head Start children are below national norms on standardized achievement and psycholinguistic tests -- although their reading readiness scores approach national norms.

4. Success is mostly in Negro centers, central cities and the Southeast.

5. Parents participate in and like Head Start.[9]

One of the reasons stated for Head Start's failure is that the program is basically good, but it hasn't had time to learn from its own experience and make improvements. After all, prior to Project Head Start there were few programs for disadvantaged or culturally different children. There were even fewer curriculum models specifically designed to remediate specific learning, language, motor and affective deficits and/or differences frequently displayed by these children. In spite of the psychological research that showed that intensive, highly organized instruction was critical, most Head Start centers, at least in the beginning years, based their programs on the "whole child" approach, emphasizing emotional and social development through unstructured play, field trips, music, dramatics, arts and crafts, storytelling and games, rather than direct intellectual stimulation.

Description of Early Intervention Approaches

Continued research in early childhood in the 1960's resulted in the formation of several approaches. One approach attempted to improve attitudes

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9 Ibid., p 11.

for and attitudes toward school by improving oral language abilities, memory, discrimination learning, problem solving ability, concept formation, general information, and comprehension. Developers of this type of approach include Gray and Klaus, Karnes, and Weikart.

Jean Piaget's theories play a strong part in this approach. According to Piaget, the greater the variety of objects and experiences that a child encounters, the more varied and flexible his learning becomes. As a child sees and hears more things, he can assimilate the new information and his ability to cope becomes stronger. There are four major skills that a typical middle class child has taught himself by about the age of four:

1. To zoom his attention in on one object or event in his surroundings and hold it in focus of his senses.

2. To value as information the clues which his eyes, ears, touch, taste, smell, bring into his brain.

3. To collect these varied facts into a filing system he made up himself and to combine them into organized ideas that make some sense of his world.

4. To use words as symbols for the facts and ideas he has collected, thus enabling himself to gather much more information, and to express himself."[10]

Weikart's program focuses on three major concerns: the curriculum, which is cognitively oriented; the teacher, who is encouraged to be active and innovative in developing her classroom program; and the home, where teachers encourage the mothers to teach their children. His curriculum is based on the Piagetian theory that conceptual development moves from the simple to the complex and from the concrete to the abstract. "The child progresses from the motor level of abstraction, where he learns to use

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[10] Ibid., p 9.

his body to experience concepts, to the verbal level, where he learns to label what he is doing or experiencing, and finally to the symbolic level, where through familiarity with objects and object representations he develops the skills necessary to think abstractly."[11]

Another approach is exemplified by the Montessori curriculum although this particular curriculum did not develop in the 60's. The Montessori program stresses sensory training and psychomotor learning through independent manipulation of didactic materials. Maria Montessori believed in deliberate sensory training in order to make tactile, thermic, baric (weight) and muscular senses more acute.[12] Another aspect of the Montessori curriculum was the Exercises in Practical Life, which included such activities as buttoning and unbuttoning buttons on a chart, tying shoelaces, pouring water from a pitcher, and caring for equipment. Although designed to teach freedom through discipline, these exercises also may provide intellectual stimulation. Pouring liquids into various shaped receptacles may aid the child to understand the concept of conservation of liquids.

The most direct of the intervention approaches is exemplified by the Bereiter-Engelmann curriculum along with the later Engelmann-Becker developments. This approach makes two assumptions:

1. For disadvantaged children, language has emerged as a common denominator of the learning deficit. While other handicaps may exist, language is at the core of the problem for such a child, and

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11 Eleanore E. Maccoby and Miriam Zellner, Experiments in Primary Education, Aspects of Project Follow Through, (New York, Harcourt, Brace, Jovanovich, Inc., 1970) p 20.

12 Celia Stendler Lavatelli, "Contrasting Views of Early Childhood Education," Childhood Education, Vol. 46, No. 5, (Feb., 1970) P 243

2. disadvantaged children as well as learning disabled children fail in school because they receive ineffective instruction. Bereiter and Engelmann offered a program that focused on systematic direct instruction in oral language, reading and arithmetic (later published as DISTAR).

Not only did they limit the type of verbalization to which the children were exposed, but they demanded that every child respond to the material. While consistency does not necessarily yield success, this consistent behaviorist approach resulted in academic gains. The program required all children to respond; the materials and teacher could not be ignored. After two years of instruction, (preschool plus kindergarten) these children not only made significant IQ, language and social adjustment gains, but prior to first grade, they were scoring above grade level in reading, arithmetic, and spelling on the Wide Range Achievement Test (Bereiter and Engelmann, 1967).

The British or infant school approach differs from the previous approaches in that its fundamental aim is for children to assume their own responsibility for learning. Children are not assigned to particular seats in the classroom, but move about freely to different interest centers set up for mathematics, science, reading, and other types of activities. After a large group session, where the teacher describes the activities available, small groups go to the various centers and thereafter move about on their own, talking freely. The children are generally free to do as they wish, with the teacher circulating among them, encouraging, prodding, and helping them. The theoretical base for this approach also stems from Piaget. The advocates of this approach believe that telling is not teaching and that, as children use good, open-ended materials, their intelligence will grow and they will develop basic concepts.

Comparison of Early Intervention Approaches

Because a majority of the innovative curricula used with disadvantaged children have only been recently developed, studies comparing the effectiveness of these models are just beginning to be published. Weikart (1969) compared a traditional-style classroom with the Bereiter-Engelmann approach and Weikart's own approach. The approach developed by Weikart was based on methods of "verbal bombardment, socio-dramatic play, and certain principles derived from Piaget's theory of intellectual development".[13] After one year of instruction, Weikart found that there were no significant gains made by one group over the others. The traditional approach worked as well as the two special approaches. Karnes (1967) and Kraft, Fuschillo, and Herzog (1968) reported similar successes with the traditional approach. However, in all these cases, the traditional preschool class was controlled by the researchers. This meant the research staff assisted teachers in planning curriculum, establishing long- and short-term goals, and constructing daily lesson plans. Such programs in experimental settings like these tend to be much more structured. Whenever the traditional approach is studied outside of an experimental structure, disadvantaged children score lower than if they were in a program designed specifically for them. (Cicirelli, 1969, Dr. Lorenzo, Salter and Brady, 1969, Karnes, 1969).

In 1969, Karnes compared five preschool intervention programs which had different degrees of structure. Structure was defined as the intensity of formal teacher-child instruction. The groups were defined as Traditional --

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13 Howard H. Spicker, "Intellectual Development Through Early Childhood Education," Exceptional Children, Vol. 37, No. 9, (May, 1971) p 631.

a project operated class of disadvantaged children, Community Integrated -- also traditional, except disadvantaged children were integrated into community operated classes with middle class children, Ameliorative -- a cognitive approach based on the Illinois Test of Psycholinguistic Abilities and the Guilford Structure of the Intellect model emphasizing language development through manipulation of concrete materials, Direct Verbal -- the Bereiter-Engelmann approach, and the Montessori approach.

All five groups began in their respective programs at four years of age. The traditional, Community Integrated, and Montessori groups went to regular kindergarten at five. The Ameliorative group had one hour of special instruction in addition to kindergarten and the Direct Verbal group remained in the Bereiter-Engelmann program another year. All the children started first grade in the third year, and received no further special treatment.

After one year of preschool intervention, the data showed the Ameliorative, Direct Verbal and traditional groups had made significantly greater IQ and language gains than had the Community and Montessori groups. The traditional class was experimentally controlled and probably had more structure than a non-experimental traditional class. When the children studied by Karnes finished first grade, Karnes found that the cognitively trained children did not differ significantly from the Bereiter-Engelmann trained children on reading and arithmetic achievement test scores. The Bereiter-Engelmann children scored one-half year lower in reading comprehension (1.7) than in reading vocabulary (2.24) on the California Achievement Test, suggesting their approach at that time taught the mechanical skills of reading, but did not stress reading comprehension. In fact, the revised version, known as the Engelmann-Becker or DISTAR approach now stresses comprehension and reasoning skills.

All of the children who entered the Karnes' Ameliorative program at age four and who were in the fourth grade in the spring of 1971, are in regular classes (N=24). Not one of the group has been referred or placed in a special class for the mentally retarded.[14] Information was not cited on the other groups.

Longitudinal Studies

In 1963, Gray and Klaus at Peabody College combined a summer intervention program with parental involvement. The summer program lasted ten weeks for four hours a day, while the home intervention portion was weekly. Children in the experimental group and their mothers received weekly home visits for a minimum of two school years from teachers who provided instruction to the children in the presence of their mothers.

There were 88 children involved in the study, with 61 residing in Nashville and 27 residing in a similar city 65 miles away. All the children were black and were selected on the basis of parent occupation, education, income and housing conditions.

The 61 children were divided into three groups. One group was involved in the summer school and parent intervention program for three years, one group starting a year later, for two years, and one group became the local control group. The 27 children from the other city were used to control and study the possible spillover effects on children and parents living near the experimental children.

In 1965, at the end of first grade, the experimental children were significantly superior on three of the four tests used at that time: word

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14 Karnes, op. cit., p 6.

knowledge, word discrimination, and reading. There was no significant difference in arithmetic computation scores. The experimental group was significantly higher in IQ score. At the end of the fourth grade, the two experimental groups were still superior to the control groups in IQ, but on achievement tests, differences in the scores were not significant. Intervention caused a significant rise in intelligence at first, which leveled off and began to decline once intervention ceased. The control groups showed a slight but consistent decline with the exception of a jump between entrance into public school and the end of first grade. All four groups showed a decline in IQ after the first grade, but the decline tended to be parallel.

It is interesting to note that the children in the experimental groups experienced only five mornings of school a week for ten weeks, plus weekly home visits during the other nine months for two or three summers. This is equivalent to a maximum time of 600 hours in the classroom, less than 2% of their waking hours from birth to 6 years, and a maximum of 110 hours in the home, or about 0.3% of the children's waking hours from birth to 6 years; yet, three years after intervention, some of the gains were still maintained. One could point to the public schools and argue that the school program had failed to sustain the initial superiority. Martin Deutsch wrote in 1964, "Retardation in achievement results from the interaction of inadequately prepared children with inadequate schools and insufficient curricula. The failure of such children to learn is the failure of the schools to develop curricula consistent with the environmental experiences of the children and their initial abilities and disabilities."[15]

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[15] Chow and Elmore, op. cit., p 12.

Another longitudinal study was done by Howard Garber and Rick Heber (1973) in Milwaukee. They developed an intensive educational program for very young high-risk children beginning before six months of age. "High risk" is a statistically based term which indicates that certain children have a critically high probability of being mentally retarded by the time they reach maturity. This study was designed not to raise IQ's but to prevent mental retardation and to allow continued normal intellectual development by mitigating environmentally depressing events.

A population survey of Milwaukee produced the following data:[16]

1. High mental retardation in Milwaukee's inner core was concentrated in families where maternal intelligence was low and family size was large.

2. There were 45.4% of mothers with IQ's below 80 who had 78.2% of all the children with IQ's below 80.

3. Low maternal IQ correlated better with the IQ's of the older siblings than with those of the younger children.

4. On infant intelligence tests, infants did equally well, regardless of the mother's IQ.

5. After infancy, the more intelligent mothers' babies maintained an average IQ, while the IQ of the slower mothers' babies declined.

Heber selected 40 mothers from a pool of mothers of new-borns who had IQ's on the Wechsler Adult Intelligence Scale of less than 75. He randomly assigned these 40 women to the control or the experimental group.

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16 Howard Garber and Rick Heber, "The Milwaukee Project: Early Intervention as a Technique to Prevent Mental Retardation," National Leadership. Institute Teacher Education/Early Childhood University of Connecticut, Technical Paper, (Storrs, Conn., March 1973).

Heber's program had two components. One was a maternal rehabilitation program that provided vocational training and improved homemaking and child-rearing skills. The other component was the infant stimulation program that provided a physical location that promoted learning, staff to manage and arrange for instruction of the children, and an educational program.

The staff consisted of paraprofessionals who were language facile, affectionate and had had some experience with infants or young children. The general educational program was cognitive-language oriented and was implemented through a structured environment by prescriptive teaching techniques on a daily basis (seven hours a day, five days a week). The program emphasized three areas:

1. language.
2. cognition i.e., classification, association, generalization, integration, interpretation and
3. motivation.

Testing areas over the developmental years included:

1. Physical maturation.
2. Standardized and experimental measures of developmental schedules of infant adaptive behavior.
3. Standardized intelligence tests.
4. An array of experimental learning tasks.
5. Measures of motivation and social development.
6. A variety of measures of language development.

On the Gessel Developmental Schedules, at 14 months of age, the data was roughly comparable for the control and experimental groups. At 22 months, the performance by the experimental group accelerated, while the control group remained at or slightly below the norms on the four scales.

On the Illinois Test of Psycholinguistic Abilities, the psycholinguistic age of the experimental groups was 63 months (measured at 54 months), while the mean for the control group was 45 months -- a difference of a year and a half.

The mean IQ for the experimental group, based on the means at each age interval from 24 to 66 months was 123.4, while the control group mean was 94.8.

These children are now in the Milwaukee public school system. Longitudinal data will be kept to determine whether or not Heber and his staff were successful in preventing mental retardation through very early and continuous intervention.

CHAPTER 5

PARENTAL INVOLVEMENT

During preschool years, a child's behavior reflects the emotional climate in his home. The quality of parental responses to his needs will encourage or limit the child's later development of social skills, emotional stability, and intellectual productivity. (Erikson, 1963). Therefore, programs for handicapped children can be substantially improved when parents are meaningfully involved in the program. Parental involvement can complement direct efforts made with the child.

Areas of parent and program needs that should be considered when developing parent programs include:

1. providing social and emotional support to reduce anxiety caused by feelings of guilt and inadequacy
2. exchanging information by providing program rationale, by relating growth of the child to interactions in the home and by providing personnel with background information on the children
3. developing methods to encourage parental participation in the program.

The attitudes of the teacher towards parents will have a tremendous impact on determining the success of a parental involvement program. The teacher must convey that she has faith in the parents ability to acquire improved skills in working with the handicapped child. She must treat parents warmly, firmly, sincerely, and differentially. The teacher or any other professional planning to work with parents assumes several roles. That person is

1. a listener, sympathetic to the emotional stresses and needs of the parents.

2. an enabler, teaching parents through her own activities how to achieve their own maximal functioning as parents

3. a model, providing a role or roles for parents to imitate

4. a reality tester

5. an interpreter, translating the professional jargon into everyday language

6. an integrator

7. a resource person

8. a teacher

9. a learner

The success of a parent program is also dependent upon the awareness that there is more than one way to involve a parent, that individualization is necessary to meet parental needs, and a belief that each parent is capable of growth.

Handicapped children place special stress on family units and individual members of the family. There is a need for family balance so that the handicapped child does not get attention at the expense of the rest of the family. It is common for parents of handicapped children to become overly protective, to compensate for feelings of rejection, disappointment, and guilt. The parents internal needs and feelings can interfere with progress and can actually undermine a therapeutic program even when they overtly express agreement and consent.

The diagnostic crisis is frequently followed by the treatment crisis. Parents may be given overwhelming, conflicting, or incompatible advice such as sign or oral language instruction for a deaf child, or advice which revives the parental sorrow and fear they experienced when they learned their child was not perfect, and advice that usurps the parents "right to know" or "right to decide."

Parents need to be given a realistic picture of their child's potential by learning about the achievements and adjustments of adults with similar handicaps. The parents also need to diminish their attempts to mold the child into normalcy. "Parents can work with their children, but they must continue to be parents."[17] One problem area in providing parents with specific techniques or procedures is that they may ignore other aspects of the child's life and their interaction with him/her.

Newly formed parent involvement programs should base their information exchange section on the verbal comments from parents, questionnaires rating areas of importance and an advisory council to conduct a needs assessment. The information exchange as it applies to parent programming may be best defined as a process by which parents become cognitively aware through the interaction of others, such as teachers, of the many aspects of their child's world. Programs must provide an opportunity for parents to learn about approaches to child-rearing, ways to use ordinary things as teaching tools and everyday experiences into learning experiences, ways to encourage language growth, ways to promote social and emotional development, and ways to find and use various resources in the community.

The following information regarding the advantages and disadvantages of large group meetings, small group sessions, individual conferences, and other parental activities has been summarized from an article by Merle B. Karnes and Reid R. Zehrbach.[18]

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[17]Norbert Enzer, "The Child Development Triad: An Overview of Parent-Child and Professional Interaction," in Parent Programs in Child Development Centers, First Change for Children, Vol. 1, ed. by David L. Lillie (University of North Carolina, Chapel Hill, Technical Assistance Development System, Fall 1972), p 8.

[18]Merle B. Karnes, R. Reid Zehrbach, "Flexibility in Getting Parents Involved in the School," Teaching Exceptional Children, Vol. 5, No. 1, (Fall 1972), pp 6-19.

One method of exchanging information is the large group meeting. Such a meeting provides information quickly and easily to large groups of people. Topics tend to be general and limited so that the largest number of parents can be served. The advantages of large group meetings are: timid persons can come without feeling ill-at-ease or out-of-place; professionals can pick relevant and critical topics of which parents may not be aware; and professionals are more likely to pick competent, interesting speakers. The disadvantages of a large group meeting are that all individual needs cannot be met, shy persons may not attend, or if they do attend, they may not ask questions. Those associating unpleasant experiences with school attendance will stay away, and those wishing to avoid facing their problem will rationalize, "There will be so many, I won't be missed."

Large group meetings are successful when: parents are involved in topic selection, speakers, data and hour of meeting; meetings occur no more than once a month; several media such as flyers, notes, phone calls through a parent network, news and radio announcements are used to notify parents of meetings; the initial notice is sent out at least one month in advance and a follow-up is used along with audio-visual aids, babysitting services are arranged; parents are involved in committee work; car pools or other transportation are arranged; there is a friendly, but not imposing atmosphere; and solicitation of funds is avoided. Teachers should take attendance at large group sessions and note comments made by various parents so as to match parents with activities that suit their needs.

Small group sessions generally invclve four to seven parents with similar needs, e.g., parents with language retarded children. Usually, small groups meetings are held at the school or at the home of a parent or

teacher at a time convenient to the entire group. These sessions are more informal and lend themselves to more socially and emotionally laden content areas. Opportunities for interaction are greater and the more reticent person is likely to talk. The disadvantages of a small group session are that cliques tend to form, excluding new parents from total involvement with the group. It is also time consuming for the teacher and it is frequently difficult to get outside speakers to talk to small groups.

Successful small group sessions depend on: frequent meetings -- as often as once a week; topics being chosen by the parents; responsibilities being rotated among the members for planning and conducting the meetings; articles, books, and cassette tapes to be reviewed during the week as the basis for the following meetings; attention to individual social, emotional, and intellectual needs of the group; content that is challenging, but not over the heads of the parents; social amenities such as dress and language that are compatible with the needs of the group; relaxed but goal-oriented atmosphere; teacher participation, but not in a dominant or condescending manner; meetings that are held for definite, predetermined periods of time -- no more than two hours; moving parents to different groups when their needs change; a teacher who is sensitive to the need for changes and provides necessary support and guidance.

Individual conferences provide for flexibility of time, place and content of the meeting. Parents can be more comfortable discussing some topics in individual sessions than in group settings. The language of the teacher can be more closely geared to the cognitive level of the individual parent.

In order to have successful individual conferences, the professional must: make the parents feel comfortable and accepted; be sensitive to individual needs; maintain an objective yet warm relationship; avoid dependent or too close personal relationships with the parents; keep discussion focused on material and avoid playing the role of therapist; refer complex cases to another staff member or through another staff member to an outside agency; discuss parent conferences with appropriate school staff members to help maintain objectivity and to improve personal performance; preschedule and preplan the conferences; establish a time limit for each conference; keep records of each conference that should be recorded after the meeting, not during; and establish continuity of materials covered during the conference.

Other parent activities include teaching the parents behavior modification. Since parents tend to focus on problems and ignore positive aspects of the child's functioning and behavior, parents should be encouraged to provide emotionally warm, secure relationships with their child and to support and reinforce progress and positive behavior. The problems that may be encountered in teaching behavior modification techniques are that parents often find it difficult to reward good and ignore bad behavior. They tend to be skeptical of the success of such techniques and sometimes ignoring a selected behavior may create problems for other family members. Misapplication can also lead to negative results.

Programmed materials can also be provided to teach specific skills. By using a 16mm film presentation or pamphlets, parents can learn skill specific procedures immediately, they can know in advance what to learn. A disadvantage would be that parents not needing a particular skill might not attend that session. Specific lesson plans can be written for parents,

but they must be clear, concise, easy to follow and must make use of easily obtainable materials. Parents can help in the classroom. Teaching in the classroom helps the parent acquire competencies in teaching other children as well as her own. The parent can indirectly teach by assisting in an area of personal talent, such as art or music. Parents can teach each other. If one parent has mastered a particular teaching skill, she can go to another parent's home and demonstrate that skill with the other parent's child. Then the host parent can practice. Cassette tapes can be used for easy listening to such topics as "Sibling Relationships with the Handicapped Children" or "Promoting Expressive Language." Parents can arrange field trips to other programs or write newsletters. Parental involvement can also result in community support for the early intervention program.

CHAPTER 6

PEECH AND STP

An early intervention program that has had tremendous influence on handicapped preschool education in Illinois is the PEECH program developed by Dr. Merle Karnes and her associates at the University of Illinois in Urbana. The term PEECH is an acronym for Precise Early Education of Children with Handicaps. The PEECH project was based on work done by Dr. Karnes with disadvantaged children (see Ameliorative program, p 102). Her people expected the handicapped children to make gains similar to the gains made by disadvantaged children, but this was not the case. Since less severely handicapped children were served by other programs in Champaign, the children enrolled in the PEECH project had an average of three handicaps per child. The mean IQ of the handicapped children was 60, while the mean IQ of the disadvantaged group at 4 was 84. As a result, the handicapped children made tremendous gains in the preschool program, but they did not become part of the mainstream population. Trainable mentally handicapped children became educable mentally handicapped children; children with IQ's of 40 made gains to IQ's of 60.

The PEECH project provides an innovative approach to the early education of multiply handicapped preschool children. The purpose of the project is to remediate or ameliorate problems so that these children can function more effectively in the home, in school, and in the larger society.

There are five key elements to the PEECH project. These are:

1. a structured classroom program
2. a training program for staff
3. the use of a paraprofessional
4. broad community involvement
5. active family participation

The structured classroom utilizes teachers, parent members, and paraprofessionals in small and large group settings. Three to four adults work with approximately ten children for three to five hours a day. Specific behavioral objectives are established for each child based on his needs and handicaps, whether they be intellectual, social, emotional, or physical. All the activities are planned so that paraprofessionals and helping family members can quickly understand the objectives for the day for each child.

Training of the staff consists of a preservice, usually involving several days of workshops, and a daily inservice session where the teachers, parents, and paraprofessionals conduct planning sessions before and after each school day. During the planning session, the development of each child is reviewed and plans are made for the next objective and activity.

Since many services such as medical, social work, counseling and economic assistance are available in the community, cooperative arrangements with community agencies are constantly being developed and maintained.

The fifth major component of PEECH is the family involvement portion. A basic principle of PEECH is that parents can be involved and learn and participate best when goals are translated into specific, concrete, problem based, positive activities that are clearly instructed.

Along with PEECH, Dr. Karnes developed a summer program for the retraining of special education teachers in preschool education for the handicapped. This project, referred to as STP (Summer Training Program), was funded by Title VI and attempted to retrain people who had skills in early childhood or special education, but not both, to become head teachers and coordinate early education programs back in their local communities.

Trainees (30) attended the University of Illinois for eight weeks and were specifically trained to teach in, direct, and/or provide consultive services to programs for the young handicapped. Students carried a full academic load and spent at least half of each day in practicum experiences ranging from actual classroom teaching to working with families and community agencies.

The evaluation of STP was based on the "Countenance" model as described by Stake (1967). This model is basically a 3 x 4 matrix with Input, Transactions, and Outputs as one dimension, and Intents, Observations, Standards, and Values as the second dimension.

The training program provided a combination of workshops and practical application where students learned characteristics of the children and their families, recent research in this field, an instructional model based on the Illinois Test of Psycholinguistic Abilities, approaches to children who manifest socio-behavioral problems, the use of behavioral objectives and criterion tasks in a classroom setting, the development and adaptation of lesson plans designed to ameliorate deficits, how to implement the Karnes curriculum with three- to five-year-old exceptional children in seven areas: language, science, social studies, mathematics readiness, art, music and directed play. They also learned how to train and supervise paraprofessionals

to teach in the classrooms, and how to train parents and other family members to more effectively work with their children.

Data was taken on the teachers before they entered the program, after they finished the program, while they were teaching in the field, and through a follow-up questionnaire when the academic year was over. The areas that were evaluated were: individualization, model usage, planning (behavioral objectives and criterion tasks), positive approach, parent program, evaluation, inservice training, identification, curriculum development, and use of aides.

When the teachers left the STP project, they stated that they had confidence in their abilities.[19] In the STP project, they had been exposed to different methods of evaluation. They had learned to work in teams and to work with other professionals by working with each other. They had an idea of what a complete preschool program should include, and were able to request materials and extra support personnel, such as a speech therapist, early in the year. They knew how to individualize the preschool program for the children and the parents, and successfully incorporate aides as teachers, by writing lesson plans for them.

The principals, directors, and supervisors of the home schools felt that those teachers who enrolled in STP returned to school very confident. The administrators felt that the STP teachers were more enthusiastic, and were more productive during the work time. The teachers took the STP ideas and were able to adapt them to local environments. They became models for other teachers, and they shared materials such as handouts, checklists, and the Developmental Guidelines developed by Dr. Karnes and staff. STP teachers

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[19] Interview with Linda Gilkerson, September 6, 1973.

kept detailed records of classroom events; they wrote lesson plans and kept anecdotal records; they used inservice time to talk about children and plan programs; and, they volunteered to work on curriculum development committees.

Of the ten sites funded with $10,000 of Title VI money (see Chapter 2), five had teachers who had attended the STP project during the summer of 1972. These sites were: West Suburban Special Education District (Cicero), Proviso Township Area Department of Education for Exceptional Children (Proviso), South Eastern Special Education District (Newton), Boone County Special Education Cooperative (Belvidere), and Four Rivers Special Education District (Jacksonville).

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STATE OF ILLINOIS
OFFICE OF THE SUPERINTENDENT OF PUBLIC INSTRUCTION
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EARLY CHILDHOOD SPECIAL EDUCATION SURVEY

JOINT AGREEMENT NAME	ADMINISTRATIVE SCHOOL DISTRICT NAME	DISTRICT NUMBER

CONTACT PERSON	POSITION

ADDRESS	PHONE (Area Code)

. Indicate the identification methods and procedures in the appropriate columns.	DURING 1972-73 SCHOOL YEAR	PROJECTED FOR 1973-74 SCHOOL YEAR
Publicized screening and program services using local media	119 ☐ Yes 9 ☐ No	118 ☐ Yes 8 ☐ No
Contacted public and private agencies serving handicapped children	100 ☐ 20 ☐	108 ☐ 21 ☐
Contacted all local preschool programs	88 ☐ 35 ☐	108 ☐ 20 ☐
Contacted local pediatricians	70 ☐ 49 ☐	92 ☐ 35 ☐
Publicized screening and program services widely in the community by using poster, flyers, and brochures	73 ☐ 46 ☐	85 ☐ 32 ☐
Conducted a door to door campaign to inform parents about screening and diagnostic services	14 ☐ 102 ☐	15 ☐ 96 ☐
Held a prekindergarten registration for all children	67 ☐ 50 ☐	70 ☐ 35 ☐
. 1. How many prekindergarten children were involved in screening?	23,876	20,086
2. Indicate projected prekindergarten screening dates for 1973-74 school year.		
. Screening Instruments		
1. Parents completed a questionnaire or developmental checklist. (If yes, please attach a copy(s) to each form)	100 ☐ Yes 38 ☐ No	101 ☐ Yes 25 ☐ No
2. List other screening instruments used or to be used and check yes or no for appropriate year.		
a. _____	☐ Yes ☐ No	☐ Yes ☐ No
b. _____	☐ ☐	☐ ☐
c. _____	☐ ☐	☐ ☐
d. _____	☐ ☐	☐ ☐
e. _____	☐ ☐	☐ ☐
f. _____	☐ ☐	☐ ☐
. Indicate the number of staff used to implement the screening methods and procedures per year.		
Number of Psychologists	208	298
Number of Speech and Language Clinicians	342	430
Number of Early Childhood Specialist (Academic training in early childhood education or child development)	87	120
Number of Nurses	240	280
Number of Volunteers	1014	862
Number of Paraprofessionals	176	264
Number of Social Workers	97	114
Number of Special Education Teachers	242	223
Other (specify)		
. How many children were identified as potentially handicapped after the screening process?	4,077	
. Indicate diagnostic procedures.		
Classroom Observation	62 ☐ Yes 36 ☐ No	73 ☐ Yes 18 ☐ No
Home Interview and Observation	81 ☐ 19 ☐	85 ☐ 11 ☐
Medical Evaluation	86 ☐ 13 ☐	85 ☐ 6 ☐
Formalized Psychological Evaluation (List Instruments Used)	81 ☐ 14 ☐	85 ☐ 9 ☐

G. How many prekindergarten children are you serving per year?	DURING 1972-73 SCHOOL YEAR	PROJECTED FOR 1973-74 SCHOOL YEAR
Number of Physically Limited	722	646
Number of Mentally Impaired	453	686
Number of Developmentally Delayed	349	1490

H. Indicate the staff involved in the diagnostic procedures.	DURING 1972-73 SCHOOL YEAR		PROJECTED FOR 1973-74 SCHOOL YEAR	
	Yes	No	Yes	No
Psychologists	97	7	99	3
Social Workers	52	34	72	24
Speech and Language Clinicians	99	7	97	2
Early Childhood Teachers	50	42	75	18
Special Education Teachers	81	21	77	16
Nurses	87	15	94	7
Pediatricians	53	33	152	23
Other (specify)				

I. Types of Direct Services Provided to Prekindergarten Handicapped Children (Indicate Number of Children Per Service and Year)	NUMBER OF PHYSICALLY LIMITED		NUMBER OF MENTALLY IMPAIRED		NUMBER OF DEVEL. DELAYED		NUMBER OF CLASSES	
	During 1972-73	Projected For 1973-74	During 1972-73	Projected For 1973-74	During 1972-73	Projected For 1973-74	During 1972-73	Projected For 1973-74
Classroom Services	350	468	243	435	389	854	147	282
Itinerant Services (Supplemental support services such as speech therapy, that would be provided to a child in a preschool program either funded through the district or by outside funds. i.e. Headstart)	354	394	168	250	567	924		
Home Intervention (Services in the home to the child, parent or both)	155	181	103	182	386	564		
Individual Therapy not in Combination with Classes	58	67	8	62	42	82		
Other (specify)								

J. Indicate the number of staff involved in providing Special Education Prekindergarten Program Services.	DURING 1972-73 SCHOOL YEAR	PROJECTED FOR 1973-74 SCHOOL YEAR
Number of Early Childhood Teachers	84	164
Number of Speech and Language Clinicians	244	360
Number of Psychologists	235	260
Number of Social Workers	95	124
Number of Paraprofessionals	116	289
Number of Teachers in Special Education Areas		
Number of Teachers - Learning Disabled	238	293
Number of Teachers - Mentally Handicapped	117	110
Number of Teachers - Trainable Mentally Handicapped	50	127
Number of Teachers - Social Emotional Disorders	126	172
Number of Teachers - Deaf/Hard of Hearing	90	67
Number of Teachers - Blind/Visually Handicapped	29	42
Number of Teachers - Physically Handicapped	54	51
Number of Other Staff (specify)		

VISITATION INFORMATION

If in the development of your program, you visited any of the ten sites listed below, please answer the questions relating to your visits.

1. Please indicate the handicapped pre-school program you visited.

10 ☐ Aurora	5 ☐ Cicero	2 ☐ Pekin
14 ☐ Belleville	4 ☐ Jacksonville (Pittsfield)	4 ☐ Proviso (Maywood)
2 ☐ Belvidere	10 ☐ Lawrenceville	
8 ☐ Carmi	8 ☐ Ottawa	

2. Check the title that best describes your occupation.

9 ☐ Superintendent	7 ☐ Psychologist	1 ☐ Social Worker
3 ☐ Assistant Superintendent	☐ Speech Therapist	2 ☐ Nurse
4 ☐ Principal	☐ ECE Coordinator	22 ☐ Other (please specify)
4 ☐ Teacher	1 ☐ Supervisor	

3. Was the visit to the pre-school program useful in giving you ideas for the development of your local program? ☐ Yes (39) ☐ No (7)
   Why or why not?

4. Has your school system implemented, or does it plan to implement, any of the ideas presented at the pre-school program? ☐ Yes (27) ☐ No (13)
   If yes, what aspects of the program do you plan to adapt to your local situation?

5. If there were ideas you planned to implement locally, but were unable to do so, what factors hindered you?

6. In your opinion, how could the Office of the Superintendent of Public Instruction best provide guidance in development of early childhood special education programs on a statewide basis? *(Use additional sheets if necessary)*